An investigation of methods used by the Southern *Nguni* in healing *ukuhanjwa* illness

By

Kholekile Hazel Ngqila

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A dissertation submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Anthropology at the University of KwaZulu-Natal (Howard College Campus), South Africa.

SUPERVISOR: Prof Victor Ngonidzashe Muzvidziwa

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ISINGCAMLISI

Iinkolo ezimalunga nempilo, ngokunjalo nezinto ezigulisa abantu, ziphenjelelwa kakhulu yinkcubeko. Iinkolo zidla ngokukhokela abantu ngokokude zibakhokelele nasekukhetheni iindlela zokunyanga. Kungoko ke, olu phando luye lwagxila ekujongeni amandla okuphilisa ngokunxulumene neendlela zokunyanga, nokuba ezi ndlela zokunyanga zinxulumana njani nesigulo sokuhanjwa kweentsana. Olu phando lusebenzise ithiyori ecacisa iindlela zokuziphatha kwabantu, ebizwa ngokuba yi-attributional theory, nethathela ingqalelo ukuba izigulo ezithile zibangelwa zizinto zomoya nezentlalo kuneendlela zokunyanga zasentshona. Olu phando luye lwakhetha ukuzama ukuqonda ukuhanjwa ngokujonga indlela yokunyanga ebandakanya zonke iinkalo. Indlela abakubona ngayo ukuhanjwa abeNguni bamaZantsi eAfrika ibonisa indlela engena ngayo 'imimoya' emzimbeni. Ngokujonga le ndlela yokunyanga yabeNguni, kuye kwacaca mhlophe ukuba kukho unxulumano olucaciswa yintlalo phakathi kwesi sigulo nemimoya. Imiba eye yajongwa ibiquka, indawo avela kuyo amandla okunyanga kolo hlobo lokunyanga lukhethiweyo, ingcaciso yesi sigulo sikukuhanjwa; ukunyangwa kokuhanjwa njengomba wenkcubeko; ingcaciso yasentlalweni yendlela ezibonwa zisebenza ngayo ezi ndlela zonyango; kunye nokusetyenziswa okuqhubekayo kwaloo ndlela yokunyanga nangona sele zikhona iindlela zokunyanga zasentshona. Olu phando, lujonga intlalo yabantu, luye lwaqhubeka kuMasipala weSithili saseOR Tambo (iORTDM) eMpuma Koloni, eMzantsi Afrika. Idatha iqokelelwe kusetyenziswa uhlobo lophando oluyikhwalitheyithivu ne-ethnografikhi - zombini ezi ziindlela zokuphanda ezijonga intlalo yabantu, ezigxile kudliwano-ndlebe lomntu ngamnye, udliwano-ndlebe olwenziwa kumaqela abantu kunye nokuqwalaselwa kweqela lesampule yabantu abangama-50. Ngokunxulumene nomba ekugxilwe kuwo kolu phando, obelukukujonga

owona mthombo wamandla okunyanga eendlela zokunyanga zemveli, iziphumo zophando ziveze imithombo yamandla okunyanga.

Iziphumo zibonise ukuba iindlela zokunyanga zasentshona zibonakalise ukusebenza ngcono. Le nto ibangele ukuba abeNguni bagqibe ekubeni zonke izigulo ezingenakuqondwa okanye zinyangwe kusetyenziswa iindlela zokunyanga zasentshona zizigulo ezingabonakaliyo. Ukungabonakali kokuhanjwa kuvele ngenxa yokuba oogqirha basentshona bayamahlula unobangela wesigulo kwiimpawu zaso, yaye bakwabonisa unxulumano oluncinci kakhulu phakathi kweempawu zesigulo. AbeNguni bona abazahluli iimpawu zesigulo, nanjengoko bengazahluli iimpawu kunobangela wesigulo. Le nto iphelele kulwimi olusetyenziswa ekucaciseni nasekuxeleni isigulo ngokunxulumene nale ndlela isetyenziswa ngabeNguni kwanaloo nto isetyenziswa ngoogqirha basentshona xa benyanga isigulo sokuhanjwa. Indlela ethandwa ngabeNguni bamaZantsi eAfrika kwiindlela zokunyanga zemveli inento yokwenza nomba wokuba ukucocwa ngokwesiko kwalowo unesi sigulo yeyona ndlela ingcono yokujongana nezigulo ezibangelwa ngumoya ongazinzanga ezifana nokuhanjwa oku, ukwenzela ukugxotha imimoya emdaka aze lowo ugulayo anyangwe nkalo zonke (emoyeni nasemzimbeni). Ukuhlanjwa ngokwesiko kukholelwa ukuba kuye 'kuthomalalise' ngendlela egxotha imimoya emdaka kumguli lowo – yiyo nale nto abeNguni basemaZantsi eAfrika bakhetha unyango olungajongi nto inye.

Kuye kwafunyaniswa imithombo emine yamandla okunyanga kwiindlela zokunyanga zemveli. Omnye waloo mithombo bubugqi bendalo namandla omoya avela kuMdali, nasebenza 'ngamandla obugqi bezinto ezithile'. Umthombo wesibini lizinga lokuthembela, ukukholwa nokukholelwa kwabeNguni ekugqibeleleni kwamandla okunyanga kunye nomntu ocebise ukuba

kusetyenziswe loo ndlela yokunyanga. Imithombo emibini yokugqibela iye yafunyaniswa ingamaxesha okwenziwa kwamasiko neendawo zokwenziwa kwamasiko ukuze ukunyangwa kokuhanjwa kube yimpumelelo.

Abantu abasabambelele kwizinto zemveli abanamonde ngakwiindlela zokuthintela, ezifana noothintela besifo sepoliyo, nanjengoko bona bekhetha iindlela zokunyanga ezibonakalayo nezenziwa kube kanye. Into engabasebenzeliyo bona ziindlela zokunyanga ezicothayo, nezisisigxina kwaneendlela zokuthintela ezisebenza ngendlela engabonwayo – yiyo loo nto baye bangazisebenzisi iindlela zokuthintela ukuhanjwa ezintsaneni.

AmaGama anguNdoqo eSahluko*: isigulo, iinkolelo, ingcaciso, ithiyori esebenzisa indlela yokuziphatha kwabantu, iindlela zokunyanga*.

ABSTRACT

Beliefs about health, as well as what makes people ill, are strongly influenced by culture. Beliefs tend to guide people as far as which healing approach they should apply. Hence, the focus of the thesis was on the source of the healing power in terms of preferred healing methods, and how these healing methods connect to the illness, *ukuhanjwa*. The research embraces attributional theory which recognises that certain illnesses are attributed to spiritual and social causes rather than biomedical causes. The study opts for a holistic healing approach to understanding *ukuhanjwa*. The Southern *Nguni*'s recognition of *ukuhanjwa* defines the illness as entry into the body by 'familiars'. An examination of the specific healing methods used by the Southern *Nguni* reveals a socially constructed causal link between *ukuhanjwa* and the familiars. Issues explored included the source of healing power in the preferred healing method; the conceptualisation of *ukuhanjwa*; healing of *ukuhanjwa* as a cultural phenomenon; the social construction of authenticity in the efficacy of the healing methods; and the continued use of the preferred healing methods despite the evolution of biomedical healing methods. The ethnographic study took place in the OR Tambo District Municipality (ORTDM) in the Eastern Cape, South Africa. Data was collected using qualitative and ethnographic research methods focusing on in-depth interviews, focus group discussions and observations amongst a sample group of 50 participants. Regarding the focus of the study, which was on the source of the healing power of traditional healing methods, findings revealed four sources of the healing power.

Findings also revealed that biomedical healing methods have been popularly portrayed to be superior. This caused the Southern *Nguni* people to conclude that all those illnesses which cannot be recognised or cured by using biomedical health system are invisible. The supposed invisibility

of *ukuhanjwa* emanates from the fact that biomedical practitioners separate the cause of the illness from the symptoms and find little correlation between the symptoms. The Southern *Nguni* do not separate the symptoms from one another, just as they do not separate the symptoms from the cause. This results in a linguistic and diagnostic discourse regarding the approach used by the Southern *Nguni* and that used by biomedical practitioners in dealing with *ukuhanjwa*. The Southern *Nguni* preference for traditional healing methods has to do with the view that ritual purification of the victim is the best way of dealing with spiritually caused illnesses such as *ukuhanjwa* to expel spiritual pollution for holistic (spiritual and physical) healing. Ritual purification is believed to have the necessary 'cooling' effect for expelling spiritual pollution from the victim – hence the Southern *Nguni* people resort to pluralistic tendencies in healing.

Four sources of the healing power in traditional healing meathods have been established. The first is the natural magic and spiritual power resulting from God's signature, working by 'sympathetic magic'. The second is the level of trust, belief and faith that Southern *Nguni* people have in the efficacy of the healing power and the person recommending the healing method. The last two sources were found to be the ritual timing and ritual space for successful healing of *ukhanjwa* illness.

Traditional people tend to lack the patience for preventive measures. They prefer dramatic, visual and once-off healing methods. What does not work for them is slow, consistent healing methods and preventive measures which work in unseen ways – hence they fail to use preventive measures for *ukuhanjwa*.

Chapter Keywords: Illness, beliefs, conceptualization, attributional theory, healing methods.

DECLARATION

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Anthropology at the University of KwaZulu-Natal (Howard College Campus), South Africa.

I declare that this dissertation is my own work. All citations and references have been acknowledged. The dissertation has not been previously submitted for any degree or examination at this university and at any other university. I submit this dissertation for the degree of Doctor of Philosophy in the College of Humanities, School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, South Africa.

NAME: K.H. Ngqila

YEAR: 2015

SIGNATURE: 

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NAME: K.H. Ngqila

DATE : 6 March 2015

DEDICATION

I dedicate this work to God almighty, Vuyiswa Legina Ngqila, my late mother and Mfundo Edward Ngqila, my son.

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ABREVIATIONS AND ACRONYMS

- ORTDM – O.R. Tambo District Municipality
- KSDLM – King Sabatha Dalindyebo Local Municipality
- PSJLM – Port St Johns Local Municipality
- MLM – Mhlontlo Local Municipality
- IHLM – Ingquza Hill Local Municipality
- NLM – Nyandeni Local municipality
- IUAES – International Union of Anthropology and Ethnologies Sciences
- ASnA – Anthropology Southern Africa
- NACSS – The North American Conference on the Social Sciences
- IAFOR – International Academic Forum
- HCBC – Home-Community-Based Care

CHAPTER 1: INTRODUCTION

1.1. Background of the study

Among the Southern *Nguni*, there is a belief that traditional healing methods work better than biomedical healing methods for certain conditions, unless the patient fails to follow instructions properly. As a result, traditional healers have rarely been accused of misdiagnosing a patient, particularly in rural areas, where they are believed to be free of Western influence. The Southern *Nguni* belief system leads them to appreciate the efficacy of their traditional healing methods for illnesses known as *abantu* or '*ukufa kwabantu*' illnesses. These are defined by Ngubane (1977) in Urbasch (2003, p11) as spiritually-caused illnesses which can only be healed using traditional healing methods. The same illnesses are called "African" diseases by Lamla (1976, p143) and Lamla (1981, p29).

Beliefs about health and what makes people ill are influenced by 'culture' and these beliefs tend to guide people in terms of which healing approach they apply. For example, those who use African traditional healing as a result of attributing illness to a spiritual or social cause rather than a physiological cause, believe that it is "intertwined with cultural and religious beliefs", and therefore, "is holistic in nature" (Truter, 2007, p57). This has influenced scholars researching illness and health to recognise the holistic nature of health, and to acknowledge the roles of 'body', 'mind' and 'soul' in health. Their field of interest is known as ethnomedicine, and falls under the study of medical anthropology.

Leclerc-Madlala (2002, pp87-95), in research conducted in KwaZulu-Natal, asserts that the differences in health behaviours are primarily a function of culture and social context, leading to a culturally shaped decision-making process of illness management. Vaughn, Jacquez and Baker (2009, pp64-67) elaborate more on the belief in the spiritual or social cause of illness by referring to bad behaviour, spiritual affliction, emotional stress, and the ill-will or jealousy of another person as attributions by some societies for ill-health. Similar beliefs have been identified among the Southern *Nguni* who often attribute ill-health to acts of witches (*amagqwirha*) using their 'familiars' (*izilwanyana zokuthakatha*).

The Southern *Nguni* often demonstrate that they believe that most illnesses are spiritually caused, especially when it comes to infants. The death of a child on the cusp of life is never easy to understand. The Southern *Nguni* see it as so far from the natural order of things that it is assumed to have its origins in the spiritual realm. Only a person who has reached the age of maturity, well advanced in years and qualified to become an ancestor after dying, is expected to die. Amongst the Southern *Nguni* people, when an individual has reached the age of qualifying to become an ancestor, it is common to refer to that person as *isinyanya* (ancestor) even while he or she is alive. They would already be imagining that person as an ancestor after death, especially if the person has lived well, according to the norms and values of the society in which he lived. Such deaths are natural, and fall within a harmonious order of events that we may expect on earth. This is illustrated by various rituals aimed at transforming the individual to an ancestor or from the mundane to the supermundane (Lamla, 1999, p159). However, the death of an infant is quite another matter. Hence they believe that illness or death of an infant has a spiritual cause.

Beliefs about witchcraft and a theory of spiritual healing appear to be held by most traditional or cultural groups of people. A question could be asked regarding what motivates people to continue with their cultural or traditional beliefs and healing practices despite the prevalence high-tech care in biomedicine. One person might respond by stating that the cause could be a lack of satisfying answers to inexplicable phenomena. The childhood experiences and adulthood experiences of a person may lead to varying responses to witchcraft and healing theories, depending on whether these experiences were positive or negative. One possibility could be that parents fear witchcraft while their children are young and relatively clueless about life and its complications. Responses of the parents to witchcraft often affect children either in a negative or a positive way and determine whether the children will be interested in continuing with traditional healing methods as adults, or not. Once these children become grown-ups, they tend to measure their adult experiences against their childhood experiences in order to determine their preferences regarding healing methods for whichever illness they confront. Should their parents' witchcraft theories be confirmed to them as adults, they may be inclined to respond in the same manner as their parents did. In cases where people have found little to confirm their parents' traditional understanding of illness and healing, two possible choices would exist; to follow in their parents' footsteps by holding fast to their belief system, despite the lack of evidence to support these beliefs, or to ignore their parents' beliefs and find other explanations and cures, based on the argument that since they have not gone through their parents' experiences they lack reasons to continue with traditional beliefs and practices.

The beliefs of the Southern *Nguni* living in the OR Tambo District Municipality (ORTDM) about illnesses, health and medicine do not necessarily apply for all the Southern *Nguni* people in

the Eastern Cape, let alone the whole of South Africa. Hence the results of this study could be used as a hypothesis and tested for veracity in other parts of South Africa.

1.2. Outline of the Research Problem

Amongst the Southern *Nguni*, there are illnesses and ways of healing that have remained unexplored and untouched by the Western biomedical system. One of these illnesses is *ukuhanjwa*. This study intends to explore the connection between the Southern *Nguni's* conceptualization of *ukuhanjwa* and their preferred healing methods for this illness. *Ukuhanjwa* is described as an attack of a person, young or old, by 'familiars' – creatures belonging to a witch - which penetrate the body through a bodily opening. The illness manifests itself when an adult or a child presents with certain characteristic symptoms; excessive sleepiness and a wide open anus with red patches around the opening, or around the genital opening or around the throat. The continued use of traditional healing methods for the condition could be based on the fact that there is a special connection between the method of healing and the nature of the illness. This study has been conducted so that it may help people to understand how the Southern *Nguni* explain the illness and the perceived source of the healing power in their preferred healing method.

1.3. Rationale of the study

With reference to the research problem in 1.2., there has been no similar ethnographic or theoretical study conducted along the lines proposed in this study to the present researcher's knowledge. The study aims to be highly ethnographic and descriptive, with a special focus on

rich, detailed data and case studies. Literature reviewed such as Petrus and Bogopa (2007); Cocks and Møller (2002); Ayibor (2008) and Pillay (1993), assisted in giving direction to the study, and seemed to the researcher to justify further research in the field of ethnomedicine, so as contribute to the body of knowledge that deals in cultural interpretations of health and illness. Of particular interest to the researcher was the perceived source of the healing power in the preferred healing method for *ukuhanjwa*, and how people connected the choice of healing method with the perceived nature of the illness. The healing method includes the whole process of finding the cure, which in this case involves guidance from ancestors as to which species of plant to use, where to find it, and when to pick it – right up to exactly which plant to pick.

The traditional conceptualisation of cultural illnesses, as other researchers refer to *abantu* illnesses, is such that biomedical healing methods are believed to be completely inadequate. This belief has not been fully explored or explained to those who subscribe to the biomedical health system, and has led to much frustration on the part of biomedical health practitioners who feel that traditional practices merely delay healing and may harm the patient. The researcher has engaged in this research hoping to find out what makes traditional people believe that they are justified in holding so strongly to traditional methods in the face of all that the biomedical world has to offer. The belief in ancestors is well known, but one may be tempted to question how this belief persists and indeed, how much it really explains when it comes to health and healing. Some would say it belongs in the past in this era of globalisation and explosion in knowledge Among the Southern *Nguni* people, it transpires, very little is considered past, in the sense of over and forgotten. Certainly, the belief in ancestors and the role they play in their descendants'

day-to-day lives remain very relevant to the concept of healing, as will be seen in this study of *ukuhanjwa*.

During the research for this study, modern medical practitioners, including those of African origin, dismissed the existence of *ukuhanjwa* as it was described to them. They concluded that the symptoms suggest sexual molestation, neglect with regard to changing nappies, or diarrhoea. They even mentioned worms as a possible cause. They would not entertain any other explanation. This is an indication of a huge gap of knowledge which exists between the modern and traditional sectors. This lack of knowledge among modern medical practitioners regarding the details of the illness and the traditional interpretation and cure for it is in line with the standard biomedical response to 'cultural' illnesses which are also labelled as indigenous health illnesses by Smith-Oka (2012, p1). This response has been noted by Truter (2007, p59). Waldron (2010, p1) has acknowledged the fact that every society embraces particular 'cultural theories' on illness, healing and health which is as a result of "diverse observations, understandings and interpretations of specific symptoms, behaviour of people affected by illness and how symptoms are uniquely experienced and explained in specific cultures".

Gangadharan and Shankar (2007, pp181-184) reiterate what this study is also concerned with, the fact that the process of globalisation has not adequately acknowledged or addressed the issue of cultural pluralism, but instead appears, in many instances, to promote a mono-cultural approach in almost all fields, including illness, healing and medicine. This, on its own, justified the research for this study so as to contribute towards promoting a balanced view of illness and health.

The researcher's personal interest was to establish a full understanding of the illness from the participants' point of view. The researcher wanted to know the illness from the perspective of someone who knew it, could explain it, and had cured it, from within the culture that produced it. The hope was that this thorough exploration of the illness and the interpretations of it would be disseminated to the relevant people who would find the information useful. Dissemination of the research findings has been done already in the form of presentations of papers at conferences and book chapters, as follows: Methods used by the Southern *Nguni* people of South Africa in healing *ukuhanjwa*; Relevance of the cultural practice of healing *abantu* illnesses in contemporary South Africa; Relevance of healing practice for *ukuhanjwa* in contemporary South Africa; Managing Witchcraft: Methods used for healing ukuhanjwa in South Africa In: *Religious Diversity Today: Experiencing Religion in the Contemporary World, Vol. 1: Suffering and Misfortune*, Edited by Dr Liam D. Murphy – Praeger Publishers; Pluralistic Tendencies in Healing: Healing Abantu Illnesses in the Contemporary South Africa In: *Advances in Knowledge Acquisition, Transfer, and Management (AKATM) Book Series*, Edited by Prof Patrick Ngulube – IGI Global Publishers.

Dissemination of the research findings helped in shaping the final draft of the study report. In addition, dissemination of the research findings in conferences helped also to confirm the rationale of the researcher for the study; that most people had no knowledge of the illness. Many who heard the presentations concurred with the study's participants that the illness and its symptoms cannot be explained by any of the hypotheses put forward by biomedical practitioners. They suggested further engagement with community members in the research area which was

selected for ethnographic study, for more discoveries about the illness. Further exploration of the illness was considered vital and further interventions by the researcher were recommended to bridge the gap between traditional communities and the biomedical health sector. To these people, it sounded like an illness which has not been discovered as yet.

1.4. Research Questions

- How do the Southern *Nguni* know that a person has *ukuhanjwa*?
- How do they heal the *ukuhanjwa*?
- What is the source of the healing power in the preferred healing method?
- Why do they use these particular healing methods for *ukuhanjwa*?
- What could be the consequences of using alternative methods of healing *ukuhanjwa* other than the preferred methods?
- What could be done in order to prevent *ukuhanjwa*?

1.5. Objectives of the Study

As has been explained above, the objectives which had to be fulfilled by the study were as follows:

- To establish how the Southern *Nguni* of ORTDM conceptualise *ukuhanjwa*.
- To determine how their conceptualisation of the illness relates to their preferred healing method.
- To reveal the perceived source of the power that heals the illness in question.

- To determine reasons for the Southern *Nguni* people to adhere so strongly to their preferred healing methods.
- To establish the perspective of the Southern *Nguni* people in healing *ukuhanjwa* with regard to the Western biomedical healing system.
- To explore possible measures to prevent the occurrence of *ukuhanjwa*.

1.6. Anticipated contributions of the study

It has already been highlighted that there is a dearth of literature on *ukuhanjwa* as a cultural illness. This dearth of information motivated the researcher to explore the illness, so as to contribute to the literature with detailed information. This information could help those who work in the biomedical field to understand the differences in knowledge between the acculturated and the enculturated. It may help them to acknowledge the varieties of ways that exist to cure conditions, and it may help them to understand, and not judge, those who adhere to traditional ways. The rich cultural heritage could easily be forgotten if not recorded.

As has always been the case and continues to be the case to this day, traditional people transfer their knowledge from generation to generation orally and have not thought of recording their cultural practices in writing for future generations. They have not thought seriously about the extinction of their cultural practices as a result of acculturation and modernisation as defined by the Western countries. Those interviewed for this study were adamant that their wish was for the cultural practice of healing *abantu* illnesses with traditional healing methods to continue. Despite the reality of globalisation and the evolving nature of cultures, they firmly believe that the understanding and cures they now have must be preserved and not lost. This research report

could help the younger generation of people to make informed decisions regarding illness, health and medicine; whether to adopt a purely traditional or religious approach, whether to transfer all trust to the biomedical system, or whether to use elements of both. It may certainly help them to understand their own choices better.

The study has also contributed to literature by providing a conceptual framework for the social construction of *ukuhanjwa* using Malinowski's functionalist approach. The same conceptual framework can also be tested for other *abantu* or cultural illnesses. Another, new conceptual framework has been developed regarding the healing pattern followed by the Southern *Nguni* people for *ukuhanjwa,* one which can be tested for other illnesses as well. It has transpired that the healing pattern followed by the Southern *Nguni* people for *ukuhanjwa* has been influenced by the fact that they lack the patience for preventive measures, or for healing methods that are slow and consistent and work in unseen ways. Instead, they prefer dramatic and once-off healing methods. The study also reveals how interpretations, meanings and language regarding illness experiences creates a discourse in terms of influencing the manner in which people respond to illness, health and medicine. Additionally, the study resulted in the establishment of a theory of invisibility of *ukuhanjwa* as conceptualised by the Southern *Nguni* people of ORTDM - a theory which can also be tested for other cultural illnesses.

The study also reveals how the Southern *Nguni* people arrive at their conclusion that witchcraft is an evidence-based theory. Lastly, the study has helped in establishing the four perceived sources of healing power in traditional healing methods for *ukuhanjwa*. The same study can be conducted for other cultural illnesses to check if the same results are revealed.

1.7. Theoretical framework

The study has been approached through four theoretical lenses so as to incorporate all aspects which could assist in probing the religio-cultural constructions concerning healing methods for *ukuhanjwa*; that is, attributional theory, social construction of illness theory and the cultural theory of modernities. The study has confirmed the proposed theories and additionally new theories have been established from the research field as indicated inder the anticipated contributions of the study.

1.7.1. Attributional theory

The attributional theory of Vaughn, Jacquez and Baker (2009, pp64-67) explains the tendency for people to make dispositional attributions for successes and situational attributions for failure. These authors assert that attributions play an essential role in the formation of beliefs concerning health and illness. According to their study, African Americans attribute illness to an external cause such as destiny or the will of God (equity attribution) and believe in the healing power of prayer accompanied by the use of ethnomedical healing methods such as *santeros* (priests of Santeria who would combine indigenous rituals with the saints of the Catholic church), *herbalista* (herbalists) and folk medicine.

In this regard, one finds that the beliefs around *ukuhanjwa* lend themselves to analysis through the lens of attribution theory. Most illnesses, according to traditional Southern *Nguni* people, are attributed to acts of witches (*amagqwirha*) or their 'familiars' (*izilwanyana zokuthakatha*). In the

case of *ukujanjwa*, it is never the witch who is blamed, but rather the familiar, which is believed to have the ability to act independently of the witch from time to time. People in the researched area emphasized that most illness is spiritually caused by an external agent, especially when it came to infants, as they have no other explanation as to why an infant would die at its prime stage. Believing that the illness is caused by the random act of a familiar and not a human being, their main concern is to heal the illness and not to uncover who or what caused it. Once it is established that the condition is *ukuhanjwa*, a familiar is accepted as the cause, and little further investigation is done as to which witch the familiar belonged to. Although it is an accepted belief among the Southern *Nguni* people that witches own familiars in order to advantage themselves and to harm others, in the case of the Southern *Nguni* of O.R. Tambo District Municipality, *ukuhanjwa*, though caused externally, is a "blameless" illness as the familiar would not have been sent by the witch.

Thus attributional theory is relevant here. The illness is attributed to a force – the act of an outside agent, namely a familiar – and not seen as arising internally by something the victim did, ate or was exposed to.

1.7.2. Social Construction of illness

The second theory which has been used for the study is the theory of the social construction of illness. Lock and Strong (2010, p6) wrote about social constructionism, explaining it as a theory concerned with meaning and understanding as the central feature of human activities. The social construction of illness is what takes place amongst any homogeneous cultural group where people have a common understanding of the cause and cure for an illness. There would be

commonalities in their understandings of particular illnesses based on their shared worldview, experiences and knowledge. Hence social constructionism is a process of meaning making which is inherently embedded in socio-cultural processes, specific to particular times and places and varying over different situations (Lock and Strong, 2010, p7). These authors raise the issue of the social construction of phenomena, which begins with social interactions and shared agreements within cultural groups. There is always a close relationship between a group's ontology and its worldview, and between a group's worldview and its understanding of illness.

In the case of the Southern *Nguni*, any form of learning space enables social interactions and constructions to occur from a cultural and spiritual perspective, with the result that the younger generation and indeed all participants understand health and illness from the same point of view. In this case, the point of view is that of a spiritual understanding of life, one which includes ancestors and other spiritual beings. The social construction of illness emanates from the shared experiences, agreements and worldviews which are passed on to all members of the cultural group, through a continuous occurrence of learning spaces.

Lock and Strong (2010, p8) acknowledge that social constructionism has an uncomfortable relationship with ideas about realism and science. One may wonder who defines realism as realistic, especially when it comes to spiritual issues; a wondering which could also be seen as socially constructed, depending on the worldview. Ken Gergen (1994a, p53) in Lock and Strong (2010, pp9-10) suggests a question which may be asked about generalised truth claims, *viz*, "Who is harmed and who gains by such claims?" The most significant thing in this regard is that, according to Lock and Strong (2010, p10), humans are social beings trying to make sense of their

experiences “by using what humans before and around them constructed and kept as meaningful”. These authors further maintain that they do not dispute the claim that humans have brains to think for themselves, but the truth is that “these brains are more linked to bodies and other people than psychologists usually indicate” (Lock and Strong, 2010, p11). They continue to state that they are not trying to be ‘anti-scientific’ by raising their arguments, but rather to indicate a different aspect of science.

Conrad and Barker (2010, p67) have sub-divided the social construction of illness into three categories. The first category is composed of those illnesses which are particularly embedded with a cultural meaning that is not directly derived from the nature of the condition. The cultural meaning influences the individual’s experience of the illness and informs him or her on what to do about it. The second category is all those illnesses which are socially constructed at the experiential level. The individual’s illness experiences determine how they interpret and live with their illnesses. The third category is that medical knowledge about illness and disease is constructed and developed by societies and not necessarily given by nature.

For this study, two categories have been considered. The first category applies, as some illnesses have a cultural meaning which becomes “medically invisible” even in this “era of high-tech biomedicine” (Barker, 2005; Brown, 2007; Kroll-Smith and Floyd, 1997 in Conrad and Barker (2010, p70)) and the third category for all illnesses applies too, whether diagnosed using Western methods or realized through the traditional approach.

As explained in the study, *ukuhanjwa* is believed to be 'medically invisible' and therefore not understood by modern medical practitioners even when described by patients, parents of patients or caregivers. The concept of 'medical invisibility' applies to the aetiology of the illness and not the symptoms, which are plain to see. This is why the two groups of people – traditional and biomedical – have two completely different responses to the illness. The social construction of this illness makes it easy for one group to understand and respond to the illness in a way that cures it, and the other to dismiss it as something else entirely and fail to respond to the illness in a manner that could satisfy the other cultural group.

1.7.3. Cultural theory of modernities

Another theory which has been considered for the study is the cultural theory of modernities as discussed by Taylor (2001, pp1-9) and Eisenstadt (2000, pp1-29) who has referred to it as the theory of multiple modernities. They both emphasize the fact that it does not matter how much influence modernity (which is supposed to operate from a culture-neutral point of view) has on a society, the outcome can never be a "pure" modernity free of the influence of a particular culture. Even what is referred to as acultural modernity is not "pure" but is influenced by the West (the Western pattern of modernity), according to these authors. This implies that acultural modernity does not really exist, since there is no pure or neutral modernity. Hence we find that even in urban settlements, where people may be said to be living "modern" lives, they continue to practice certain behaviours that are derived from their mother culture. They are modernised not according to some neutral pattern of "modernness" but according to the ways of their culture. Beliefs surrounding *ukuhanjwa* cut across the spectrum of socio-economic categories, and include people in urban areas, the educated and the uneducated, the young and the old, Christians

and traditionalists. They all use indigenous medicines and also indigenized medicines with the inclusion of household products used in ways not originally anticipated by the manufacturer. This applies particularly to the young and to Christians, who prefer to use household products on their own, rather than plants as directed by a diviner. This may be because of practical reasons (no affiliations with rural areas and diviners) and because of the influence of Christianity, which disallows consultation with ancestors and in many cases distrusts natural healing methods as something associated with diviners. Thus their responses fit into a culturally-informed modernity.

1.7.4. Functionalism

The last theory is the functionalist approach by Malinowski (Moberg 2013, p191). The theory insisted that people engage in their cultural practices (i.e. actions) as a means of meeting their individual needs despite Radcliffe-Brown's claim that people's cultural practices are meant to encourage and maintain social solidarity and solid social structure irrespective of their individual values, individual interests or even individual goals (Moberg, 2013, p183). This literally means that people are required to forfeit their needs for the sake of social cohesion, according to Radcliffe-Brown's structuralism. In this regard, it cannot be denied that the manner in which Southern *Nguni* people of ORTDM have conceptualised *ukuhanjwa* follows Malinowski's approach of functionalism. The social construction of *ukuhanjwa* could be linked to the functionalist approach when taking into consideration people's interpretation of or response to the stimulus that suits the needs or interests of the individual. In this case, the younger generation has to choose their interpretation of their illness and the manner in which they respond to it. In

their decision-making they would consider their illness experiences and interpretations first, without prioritising government and biomedical structures that exist for dealing with ill-health.

1.7.5. Conceptual framework

The conceptual framework for this study has been drawn from all of these theories, with the intention of making sense of the factors which have led to the Southern *Nguni's* current conceptualisation of the illness in question. The attribution of the illness to outside factors and not those inherent in the afflicted person is an indication that attributional theory applies to the Southern *Nguni* understanding of *ukuhanjwa*. The fact that familiars are commonly understood as the cause is the result of a process of social construction, a process which is frequently not understood by outsiders. It leads them to dismiss the illness as non-existent or belonging to the realm of "theological" illnesses, a term used by the biomedical system. To the people who know and experience *ukuhanjwa*, it is real and is one of many "*abantu*" illness, i.e. illnesses known only by indigenous people and "medically invisible" to the biomedical world. The fact that the experience and interpretation of the illness is the same amongst "modernised" Southern *Nguni* people and rural Southern *Nguni* people is an indication of the applicability of the cultural theory of modernities. Clearly the modernity of these urban people is not "pure modernity" or "acultural" but indicates that cultural modernity is at work. In all of the decision-making processes leading up to a person's chosen path of action in response to the illness, Malinowski's functionalism applies; people choose a response based on what is deemed to function best for them, irrespective of the convenience or supposed superiority of government approved structures.

1.8. Summary of chapters of the thesis

Chapter 1, as the introduction of the dissertation, has outlined the background and the statement of the research problem, the research questions, its objectives, its theoretical framework, its conceptual framework, the intended contributions of the study, and the definition of terms. It also includes a summary of the chapters of the dissertation:

Chapter 2 presents a literature review which is used both to validate and appraise the findings, and to enable the findings to validate and criticise the literature. The literature thus plays a hypothetical function and is referred to at the end of the study as either confirmed or refuted. The literature review covers international, national, and provincial studies and reports that deal with the conceptualisation and responses of various cultural groups to illness, with a particular focus on African conceptualisations. The chapter discusses the role of worldviews in constructing illness and health, revealing the influence of culture in defining illness. Socio-religio-economic conditions are referred to as determinants for illness causation and the role of witchcraft is examined. In addition, the chapter reviews the literature on the influence of culture in determining healing methods. This includes how traditional African healing methods and medicines were originally discovered, major factors which promote the continued use of traditional healing methods, the shortcomings of traditional healing methods as well as the pluralistic nature of help seeking. Lastly, the chapter examines the Western culture of modernity and its empiricist paradigm. The effects of globalisation and the hegemonic tendencies of biomedicine are discussed, and issues surrounding the practice of culturally congruent health care are also looked at.

Chapter 3 describes the research design and methodology used in this study, and outlines in some detail the process of ethnographic and qualitative research methods which were used, including the instruments used to gather rich data. It explains how the analysis and interpretation of data were done simultaneously so that gaps in data could be filled immediately where analysis revealed them. The process of choosing the research area, target population and sample size is described, and the manner in which entry into each community was attained is also described. The matter of the delimitation of the research area and the scope of research for feasibility purposes is also discussed, as well as ways in which the researcher overcame limitations and challenges for better results. The process of gaining permission and the importance of following protocols with regard to entry into communities is also covered.

The chapter also pays attention to the matter of respect and ethics, with reference to the Constitution of the Republic of South Africa. Respect for individuals and for the culture and its beliefs are shown to be fundamental to the gathering of good quality data. The chapter discusses how the researcher's choice to work without the aid of assistants impacted on the quality of the research results, ensuring authenticity and consistency. Lastly, it discusses how the researcher ensured the trustworthiness of her data and the matter of the ethical and correct treatment of the raw data.

Chapter 4 presents a 'thick description' of *ukuhanjwa* as a 'spiritually-caused' illness. The chapter demonstrates how biographical, situational, relational, and interactional 'thick descriptions' by both the participants and the researcher have been employed to render more information and to contextualize the manifestation of *ukuhanjwa*. The chapter presents the

identifiable symptoms of *ukuhanjwa,* as understood and recognized by the Southern *Nguni* people of the ORTDM, and elaborates on the conceptualization and social construction of *ukuhanjwa*. It outlines the conceptual framework for the illness as the basis for the belief that *ukuhanjwa* is a spiritually-caused condition and an "*abantu*" illness or "*ukufa kwabantu*". The chapter also elaborates on how both the conceptual foundation laid by older members of the society and people's experiences serve as motivation for the younger generation to continue to believe in and practice traditional ways of healing this. Lastly, the chapter also includes the aetiology of the illness in question as conceptualized by the Southern *Nguni* people of the ORTDM. The conceptual framework for the aetiology of *ukuhanjwa*, as contextualized by the Southern *Nguni* people, has been drawn from attributional theory.

Chapter 5 deals with the implications of illness and disease for the individual and society at large and outlines both the context of healing, as understood by the Southern *Nguni*, and the methods employed in healing. The chapter also elaborates on how different cultural interpretations have led to the development of cultural norms and social institutions concerned with health and well-being that vary from society to society. The chapter discusses how the history of the discovery of traditional medicine for *ukuhanjwa* is particularly relevant as it has its roots in the beliefs, cosmology and perceived sources of power as understood by the Southern *Nguni* people. This chapter also examines how the various forms of *ukuhanjwa* with their different symptoms inform which healing methods are used, the healing methods themselves, and the argument for the continued use of these methods. The chapter also elaborates on the perceived sources of the healing power in these traditional healing methods. This encompasses the person who

recommends the method of healing, how the healing methods are revealed to the healer and the methods used to prepare the medicines

Chapter 6 discusses various discourses on illness, health and medicine, covering the issue of power relations, witchcraft as an evidence-based theory and interpretations and meanings of illness experiences as related to socio-economic conditions. The issue of poverty in help seeking for illness is considered. The hegemonic tendencies of the biomedical health system with reference to globalisation and the social and political processes that give the biomedical health system its hegemonic tendency are observed.

The chapter also covers the concept of the 'invisibility' of *ukuhanjwa* to biomedical health practitioners and how this has contributed to the continued use of traditional healing. Biomedical responses to the 'invisibility' of *ukuhanjwa* are also considered. The dual concepts of cleanliness and ritual purification are shown to be different ways of approaching the matter of illness; different, yet not unrelated, and shows how these concepts relate to the cultures from which they arise. The apparent "contradictions in meanings" of these two concepts are explained. The chapter also addresses the reality of a pluralistic approach to healing *ukuhanjwa*, as a means of responding to the 'invisibility' of *ukuhanjwa*, and the importance of this pluralistic approach in the midst of social development. Lastly the chapter examines why it is that *ukuhanjwa* continues to be treated by the traditional method; how this method is related to the perceived source of healing power, and how its continued use defies the dominating influence of the Western biomedical model.

Chapter 7 focuses on whether or not all the research questions have been answered, and if not, suggests further research to close those gaps created by the questions which have been left unresolved. It looks at whether the objectives of the study have been met and if not, suggests ways in which those objectives may be met.

Throughout the study, the literature and the theoretical framework that the literature reveals are used as a hypothesis. Chapter 7 examines whether the theoretical framework and literature have been proved right or refuted by the outcomes of the study and if refuted, whether or not a new theory has emerged as a result of the study.

The chapter discusses how the gaps caused by the limitations of the study have disadvantaged the richness of the data and how these gaps may be addressed in the future. Lastly, the chapter reviews the Southern *Nguni* contextual meaning of *ukuhanjwa* and how this shapes the aetiology and healing methods for the illness. It shows how the perceived source of the healing power ensures its continued use even as part of a pluralistic approach to healing. The chapter concludes by locating the Southern *Nguni* worldview and conceptualization of illness, health and medicine within the era of globalization, and highlights the implications of the study for the future.

1.9. Definition of terms as used in the dissertation

- Familiars – According to Petrus and Bogopa (2007), familiars are believed to be supernatural spiritual agents that can be controlled only by the witches who have created them. They are also believed to be demonic animals used by the witches to execute their

notorious acts of witchcraft. Although they are spiritual entities, some of them can actually be seen.

- Pollution – this is the result of certain actions or the presence of a bad spirit, both of which are believed to cause misfortune or death. Polluting actions are those that involve breaking a taboo. An example would be a woman during her menstrual period. Traditionally, she should not come into contact with a new-born baby. If she breaks this taboo, she is believed to pollute the baby, causing the baby to fall ill.
- Spirit possession – this is a traditional illness which is often confused with mental illness. During spirit possession, a person will display characteristics and have abilities that are different or beyond that of the person in his/her natural state. A female will speak with a male's voice, and vice versa. The unfamiliar voice is believed to be that of the spirit which has taken possession of the person. Such a spirit will also enable the possessed person to achieve extraordinary feats, such as displaying unnatural strength or speed, or walking on water. The condition can be reversed by using spiritual means, unlike most true mental illness.
- Ritual purification – this is any substance or method which is used to heal a spiritually-caused illness or a method used to cleanse a polluted person so as to prevent illness or misfortune. It could also be a method used to cleanse a person who has experienced misfortunes as a result of deviating from the expectations of the ancestors. It cannot be equated with physical cleanliness.
- Traditional people – these are people who still strongly believe in traditional practices irrespective of their level of education (literate or illiterate), location (urban or rural), or

status (rich or poor). These traditional practices could be purely indigenous, indigenised or modernised indigenous.

- Traditional medicine – this is medicine that is both indigenous (usually plants, animal fats or minerals) and indigenised medicine (household products such as toothpaste used in ways not originally intended by the manufacturer, for purposes of healing).
- Indigenous – this refers to an object or act that is endemic to a place or a group who use it in ways it was originally intended to be used.
- Indigenised – this refers to a modern object or act used in ways not foreseen by the manufacturer, to suit the needs of the group of people who use it.
- Literate or educated people – these are people who have attained Western formal education. This type of education is different from traditional formal education.
- Cultural modernity – this is anything which is considered to be modern but still has traces of the culture of a particular group of people. This could be clothes, type of education, types of behaviour, etc.
- Acultural modernity – this is a contradiction in terms since the cultural theory of modernity shows that all modernities are culturally influenced and therefore, there is nothing which is "acultural". It is usually taken to mean Western modernity; the modernity of the dominant culture.
- Cultural congruency – this refers to a harmonisation of cultures so that no single culture dominates.

CHAPTER 2: LITERATURE REVIEW

2.1. Overview

This chapter reviews the literature on traditional healing practices, both in South Africa and internationally, with a view to placing the discussion of *abantu* illnesses within a wider context. Empirical literature can be viewed as being hypothetical to the science of research, for the research, such as this study, either confirms or refutes the literature. This literature review includes research reports from around the world which reflect the cultural nature of the conceptualisation of illness. The empirical literature reviewed does not cover the illness *ukuhanjwa* specifically as this study proposes to do. The illness was mentioned in passing as '*isilonda*' or '*ukwebiwa*' and the use of toothpaste for its cure was mentioned, but nothing was posited regarding the Southern *Nguni* people's conceptualisation of the illness and their holistic responses to it.

This chapter looks at various worldviews on illness and health, revealing how culture influences the definition of health and illness. This of course includes the dominant Western culture, with its empiricist paradigm, which exerts pressure on traditional healing systems to conform to its own standards. Western culture leaves little room for culturally-attuned definitions of illness. It has in some ways ensured, by its very insensitivity, the tenacity and continuation of culturally-rooted healthcare. While the focus of the literature review has been on Africa and African interpretations of illness, frequent reference is made to research conducted internationally.

2.2. Different worldviews on illness and health

Worldviews are understood to be influenced by culture, and result in different responses and practices depending on the society in which they are rooted. Thus different meanings and diagnostic results are attached to illnesses, depending on where in the world they occur.

Ross (2010, p45) writes on Africa, ethics and traditional healing as emanating from African spirituality. She explains that in traditional African medicine, disease and disorders are experienced as social or psychological disturbances, causing a loss of personal equilibrium. Eastman (2011, p187), too, states that in African culture, ill health is thought to proceed from a lack of a synthesised, balanced state within the individual, between the individual and his or her social habitat – immediate kinship and beyond - and between the individual and the natural environment. According to Ross (2010, p45), ill-health manifests in the form of physical or mental problems. It is likely that the mental illnesses to which Ross alludes are *amafufunyana* (spirit possession) and *ukuphambana* (mental illness). The African interpretation of these mental illnesses is that they are spiritual conditions of the individual, brought about deliberately by those who commune with the spiritual world for personal power - witches. According to the African perspective there is a difference between *amafufunyana* (spirit possession) and *ukuphambana* (mental illness). In *amafufunyana* (spirit possession), evil spirits thought to inhabit a person would be male in the case of a woman and female in the case of a man. Thus a woman so possessed would speak out in a male voice, and the man so possessed would speak out in a female voice. Victims of *amafufunyana* exhibit all the characteristics of what in Western culture would be some form of purely mental derangement. They would cry out loudly and incoherently and be non-communicative with normal persons. An additional element not normally present in

Western “mental illness” is the apparent ability to run at a tremendous speed, to the point that other people are quite unable to catch the person. *Ukuphambana* (mental illness) is seen as the prolonged condition of self-neglect as a result of the deliberate act of the witches but in this case, the evil spirit would not be residing inside the body of the victim.

Both of these conditions and their interpretations reflect the African mind-set and culture as one where the spiritual dimension of life is far more real and alive than it is to the Western mind. Both are ‘*abantu*’ illnesses or ‘*ukufa kwabantu*’ (Ngubane, 1977 in Urbasch, 2002, p11) requiring a traditional African approach to healing. The Western biomedical approach would be considered inadequate to deal with the totality of these conditions.

According to the African worldview, mind, body and spirit are viewed as one entity and no distinction is made between physical and psychological problems (Ross, 2010, 45). Ross’s statement might be true to some extent, but where she uses the term “psychological”, African culture would use the term ”spiritual” and infer a great deal more than conditions contained within the mind and body of the individual. Spiritual illnesses are seen to reach out beyond the individual, and to have their cause in various states of the spiritual world, thus emanating from outside of the person. They may be acts of a witch, or a manifestation of ancestral dissatisfaction for some misconduct or omission, or, frequently, the refusal of a person to obey the calling to become a diviner.

Biomedicine, on the other hand, separates mind, spirit and body. Disease is viewed as a purely biological malfunctioning in which illness manifests in chemical, anatomical and psychological

changes. The African view is that illness and health are holistic, taking into account all aspects of life including that which is not seen, while the biomedical view holds that all conditions can be defined scientifically, and empirical evidence attests to the existence or otherwise of any phenomenon.

Regarding empirical evidence, one should not assume that the African medical system discounts it. Successful cures brought about by traditional medicines are taken as evidence that they are valid; confessions by witches are seen as a clear evidence of the causes of specific illnesses. Incidents of sudden death in healthy individuals, as explained by Whiting (1977, p216), are associated with witchcraft when no evidence of obvious degeneration has been present. The Southern *Nguni* people of South Africa in the OR Tambo District Municipality (ORTDM) hold a similar belief, according to Ngqila (2002, p2), regarding infant deaths. These are invariably seen as spiritually-caused, as the understanding is that death at this stage of life is unnatural. The infant has not lived long enough to contract diseases, and hence outside forces are blamed.

In many cases neither natural causes nor witches nor ancestors are blamed; instead the illness is seen as an unintended act, as far as any other human being is concerned. The illness or even death may be seen as a consequence of "unintended pollution" of non-wilful causation (Ngqila, 2002, p20). Here witches would not be blamed as 'ultimate causes' (Hart, 1978, p74) but instead spiritual agents or the familiars of witches would be blamed as the 'efficient causes' (*op. cit.*), and the magical intrusion of foreign objects or the actual familiar into the body of the victim would be the 'instrumental cause' (*op. cit.*). This confirms what Eastman (2011, p193) has said;

that, at particular instances, agents of illnesses might not be regarded as the cause of illnesses but as catalysts for illnesses.

Good (2001, pp89-96) and Douglas (2010, p9-10) raise the issue of language as a cause of misunderstandings between the Western and African interpretations of illness. In agreement with Good (*op. cit.*) and Douglas (*op. cit.*), Lupton (2012, p2) emphasises the significance of language in illness, health and medicine, where a pattern of words, figures of speech, concepts, values and symbols emanate from a particular culture and may cause confusion and apparent contradictions. Lupton (2012, p2) states that historical, political and cultural settings can be used to help uncover meanings in illness, health and medicine. Good (2001, pp89-96) makes the example of blood as being viewed both as the source of life and as a killer. Some religious groups do not allow blood transfusions from one person to another without the blood being ritually purified first. The omission of this ritual purification would be seen as potentially fatal. Blood is seen as life only when it is running inside the veins of a person; outside the body it symbolises death.

The concept of ritual purity features strongly in the medical practices of the Southern *Nguni.* Different understandings of the concept of "purity" or "cleanliness" may be responsible for much misunderstanding between practitioners of African healing and biomedical practitioners. The Southern *Nguni*, who practise traditional medicine, consider everything used to achieve healing and protection from misfortunes as ritually pure and therefore "clean", though not necessarily hygienically clean. The fact that biomedical health centres focus solely on physical hygiene to bring about cleanliness or purity means, in the eyes of traditional practitioners, that their healing is doomed to fail. They have omitted the most important step - ritual purification. On the other

hand, ritual purity in the eyes of the biomedical practitioners contributes nothing to healing and in fact harms it, as the means to achieve it are seen as unhygienic. Whiting (1977, p245) points out that according to the African understanding there could be objects which are dirty but not spiritually polluting, while there could also be objects which are both dirty and polluting. Here the words used to describe the difference would hardly translate clearly and could contribute to misunderstandings when explained to the Western mind.

Regarding the concept of purity, in some parts of India, certain natural processes and products of the body such as birth, death, menstruation, faeces, nail, hair, and reproductive fluids are viewed as sources of involuntary pollution (Whiting, 1977, pp246-247), since people have little control over these aspects. Interestingly these same products of natural processes are also used to bring about misfortunes and death for some people within the African understanding of illness, as mentioned by Ngqila (2002, pp81-128) and Naidu and Ngqila (2013, pp55-70). Witches, for example, are thought to use the placenta to cause infertility, and the hairs of a person may be gathered to use in witchcraft against that person and his family. Those who hold these beliefs would therefore necessarily practise vigilance by not allowing any waste products of the body to be carelessly scattered, for fear of being used for witchcraft – thus living a life of fear.

The different worldviews on illness and health influence peoples' understanding of what healing is supposed to encompass, and often guide their pattern of help seeking. As has been mentioned, illness in the African context results in a loss of personal equilibrium; traditional healing therefore is all about restoring balance, equilibrium and harmony by re-integrating the person with his or her community, the earth and the spiritual world. It is not just about alleviating

physical symptoms (Ross, 2010, p45). On the other hand, Eastman (2011, pp194-195) views traditional healing as helping only to alleviate the psychological stress of illness, by providing answers to questions behind the pain, reducing it to a known and confront-able entity, from a specific cultural point of view. This suggests that the author has no trust in the perceived causes of and remedies for traditional illnesses, viewing the cures as merely stress-reducing. It is a common point of view amongst those who subscribe to Western ways of thinking and certainly dominates the biomedical view of traditional healing, which does not recognise *'abantu'* illnesses as having any validity. Its practitioners are usually unable to acknowledge that two completely different and complex world views are in operation. The same view is also posited in a recent study by Maveni (2014).

Socio-religio-economic conditions impact on the worldview of people and the choices they make when it comes to healing. These conditions include level of education, economic status and the influence of Christianity, as well as such practical matters as travel distance to the health centre. Individuals vary greatly in their responses to these conditions. Some would opt for total acculturation and disregard traditional practices, while others would adopt a pluralistic approach, straddling, as it were, both worlds in their quest for healing.

Practical matters such as distance from clinics, hours and quality of service, and availability of medicines would strongly impact upon people's experiences of biomedical health centres and in many cases, dissatisfactions with all of these aspects ensures a steady supply of customers for the diviners. The diviner is flexible in hours kept, and quality of service is always personal and intimate. Unlike with biomedical centres, no one is turned back from a diviner empty-handed. If

the remedy turns out not to work, blame is usually not apportioned to the diviner, and certainly no one would expect to have received a medication that is unsuited to the problem – as is frequently the case at clinics, where all sorts of serious illnesses may be "treated" with an analgesic, simply because appropriate medicines are in short supply. Where a prescribed traditional medicine does not work, the assumption would be not that it was the wrong medicine, but that the person did not follow the instructions quite correctly. Lamla (1991) explained this view in greater details.

Based on reports from all over the world on the effectiveness of traditional healing for certain illnesses, the World Health Organization (WHO) saw a necessity to integrate biomedical health systems with that of various social systems, to form a "biopsychosocial" system of health, illness and disability (Ross, 2010, p45). The move was an example of the hegemonic nature of biomedicine in that the biomedical health system would still prescribe how this amalgamation or integration should be accomplished. Traditional health systems would be acknowledged and would be "fitted into" into the world of biomedicine, and not the other way round.

The global aspect of biomedicine has influenced people in general towards acculturation, moving them away from traditional healing methods towards using biomedical healing. And yet adherents of traditional healing remain. The threat of illnesses and death evokes such fear in people that they desire an immediate solution. As a way to overcome the fear that attends sickness, many people turn to traditional healing methods as an emergency measure. Yet the assumption cannot be made that it is "emergency" treatment only or practised only where access

to biomedical centres is limited. Traditional medicine is the first choice for many people, with biomedicine believed to be inadequate for many serious conditions.

According to Lupton (2012, pp3-4), illness has always been viewed as social deviance, with the ill person perceived as a failure in terms of conforming to social expectations and norms. This is true even amongst urban dwellers and those educated according to Western values. A person may be the family breadwinner, regarded as holding the family together economically. Sickness in this case means disaster not only for the individual but for the family. Illness is an unnatural state of the human body (Lupton, 2012, pp3-4) causing massive disruption, and traditional healing methods would be used as means not only to cure the person but as a way to restore and maintain social order.

Moberg (2013, pp180-196) mentions how Malinowski and Radcliffe-Brown analysed illness from different angles. Moberg (2013, pp180-196) and Lupton (2012, pp3-4) discuss illness from Malinowski's functionalist point of view as deviation from societal expectations. Each member of society is expected to perform everyday activities as a contribution to the economy of the household and that of society at large. When a person is ill, he or she experiences physical and social dysfunction, becoming dependent upon other members of the society. A way of restoring order for this person would be to find a means of healing the individual as a matter of urgency. On the other hand, Radcliffe-Brown did not approach analysis of activities and behaviours of members of the society from an individual point of view and individual gain and interests but as means to achieve social cohesion.

Some people view illness as a punishment and an unnatural state of the human body – hence the need for urgent alleviation of illness, whether through biomedical or traditional healing methods. Moberg (*op. cit.*) raises the issue of the strong fear of death by people who are experiencing illness. This makes many people respond in a manner which focuses on alleviating fear, and one of the chief ways of doing this is through the use of rituals. Rituals have an effect on the level of fear, instilling a sense of calm and control. In countries where biomedicine is prioritised by their governments, those who decide to use traditional healing methods would be deviating from the expectations of their governments, in favour of satisfying their personal need to display respect for their elders, to keep fear at bay and to avoid blame in case of death of the ill person.

2.3. The influence of culture in defining illness causation

The impact of culture on illness and health cannot be over-emphasised. It has always been noted that, both in rural and urban areas, evidence of attributional theory, the social construction of illness and the cultural theory of modernities cannot be denied, as explained in the theoretical framework of the study. As explained by Kleinman (2010, p86), different medical systems employ different explanatory models to make sense of disease and give meaning to the individual and his social experience of illness. What is perceived as illness in one culture may not be perceived the same way in another culture. That leads to the concept of the 'medical invisibility' of certain illnesses when viewed by the system of another culture. Those who subscribe to the Western system of biomedicine refer to illnesses which are 'medically invisible' as 'theological illnesses' (Anderson, 1996, pp23-29). This could be because empirical testing for these kinds of illnesses has not been conducted according to the standards of Western culture and biomedicine.

There is an element of evolution in all cultures, with the pace of evolution differing from culture to culture. Because the Western culture and its biomedical health system appears to have evolved at a faster pace than others, it developed a hegemonic tendency, measuring all other health systems against itself. As a result, it holds the position of being at the top of a hierarchy with all other systems disqualified entirely. This concept of evolution of cultures was posited by Tylor (1965, p6) in Moore (2012, p9) who stated that:

> Culture or civilisation consists of knowledge, beliefs, art, morals, customs, and other mental constructs; because human mental processes are universal, human societies have developed culture along similar trajectories, characterised by progress and expressed in the evolution of culture.

Thus the point of this author is that evolution follows a similar trajectory in all cultures but at different paces, giving rise to the categorisation of cultures and their health systems as superior and inferior. In this regard, Barker (2003, p51) encourages societies to remain open to the possibilities of new inventions and new vocabularies that might persuade people to look at the world differently, for a revolution in thinking and ways of responding to stimuli. The so-called inferior health systems have become influenced and dominated by the so called superior health systems. The outcome, however, has not been the adoption of purely "modern" healing methods but rather the adoption of "cultural modernity". Taylor (2001, pp1-9) stated that nothing comes out as purely "modern" as a result of modernisation; instead the phenomenon of cultural modernity emerges. Cultural modernity can be seen as an expression of resistance to being placed in the past, as the so called inferior culture. It is a means of preserving culture and

identity. Indeed, if cultural evolution is to be accepted, then in fact all health systems evolved from a common starting point; that of the magical-religious healing concept.

Theological illnesses have been explained by Anderson (1996, pp23-29) as illnesses which occur as a result of contagious magic or familiars coming into contact with the body of an individual. The Western biomedical system views the so-called theological illness through the prism of cause and effect. Spiritual explanations are not understood, since they are full of magical and religious thinking and terminology and, according to the biomedical practitioner, distorted by ill-founded beliefs (Anderson, 1996, p23).

Those who subscribe to Western biomedicine choose to refer to theological illnesses as ill-founded because, from the Western biomedical point of view, the worldview giving rise to these illnesses and their explanation is completely foreign. But to those who believe in the reality of these illnesses and their causes, they are perfectly in line with a worldview that has sustained generations of people and therefore completely real. They are theological in the sense that they arise from the spiritual world; either as a result of the "unintended pollution" of familiars coming into contact with a person, or as a result of witchcraft, or as a result of the anger of the ancestors who withdraw their protection for some reason, leaving the person vulnerable to attacks by evil spirits. More will be discussed in the findings on how contact with familiars is thought to result in *ukuhanjwa* as one example of a so called "theological" or *abantu* illness.

2.3.1. Socio-religio-economic conditions and culture as determinants for illness causation and health

Friend-du Preez, Cameron and Griffiths (2009, p346) discuss the effect that socio-religio-economic conditions might have in shaping the worldviews of people, in addition to the effects of culture. One finds that there is no guarantee that the individual who has a high socio-economic status, is well-educated and is highly spiritual in terms of Christianity, would abandon his/her traditional worldview. The worldview might be diluted to some extent, but it would be still in existence in one way or another, confirming the theory of cultural modernity.

In this regard, one might mention members of the Zionist Christian Churches (ZCC) which fall under African Independent Churches (AIC), as well as many in the mainline churches such as the Anglican, Presbyterian etc, where there is no guarantee that people have abandoned their cultural practices or traditional African worldview. Friend-du Preez, Cameron and Griffiths (2009, p346) maintains that those who are highly educated and with a high economic status use less traditional medicines than those who are less educated and have a lower economic status. Nonetheless, the fact remains that proximity to and the ability to afford high quality biomedical health care does not guarantee an individual's desertion of the traditional worldview or healing methods. This is interesting as it implies that the move from one worldview to another is not the inevitable result of education. It seems to go deeper than that. Many adopt for using both systems – the pluralistic tendency. The above authors point out that there are many well-educated high earners who retain a strong belief in the power of traditional healing methods, to the extent that they would overlook high travelling costs for the sake of reaching the high quality services and outcomes found in these healing methods.

2.3.2. Conceptualisation of witchcraft in relation to illness and health

In the "Western scientifically defined rationalistic framework", witchcraft might not be recognized as 'real', but within African communities, it is viewed as a reality for most people (Petrus and Bogopa, 2007, p.2). These authors claim that for both urban and rural African communities, witchcraft exists as a viable and plausible explanation for misfortune, illness and death. The difficulty with many Western/biomedical practitioners is that they regard human beings as bound entities, limited to their own "internal logic", without any connection to supernatural forces – hence they interpret whatever happens in the human body only in natural terms (*op. cit.*, p.5). This is the reason that Western/biomedical practitioners centre their beliefs and values on science, technology and the institutions which control and disseminate them. They view the human body as a machine that can be taken apart and put back together to ensure proper functioning and health (Davis-Floyd, 1990, p275).

Indigenous people, on the other hand, only know of their experiences of the interaction between the natural and the supernatural, and to them, the causes of illness are to be found in this interaction. Natural phenomena include plants, roots and herbs, and spiritual phenomena which includes the entire world of beings who surround the living people unseen, and who can be contacted through divination. Eastman (2011, p187) stated that in the traditional worldview, people are considered healthy only when they have a synthesised, balanced relationship within themselves as individuals; between themselves and the social habitat within which they live, and between themselves and the natural environment through which they move. To this one would add the relationship between themselves and the spiritual world.

Evans-Pritchard (2010, p19) claims that amongst the Azande people, witchcraft is so intertwined with everyday happenings that it becomes part of their ordinary world. Rather than experiencing surprise by the acts and outcomes of witchcraft, the Azande people become angered and feel insulted. Evans-Pritchard (2010, p19) highlights this response of the Azande people to witchcraft by stating that "it is the aggressiveness and not the eeriness of these actions which Azande emphasise when speaking of them, and it is anger and not awe which we observe in their response to them". The Azande people do not trust anyone, including their neighbours, when it comes to witchcraft. The same applies to the people of Tafeni in the Eastern Cape of South Africa, particularly mothers, who do not trust even their relatives, especially mothers-in-law (Ngqila, 2002); an indication of the extent to which belief in witchcraft dominates their everyday experiences. Similarly the people of Nyasaland often suspect some member of their immediate circle of neighbours as the cause of their misfortune, but one which cannot be confronted openly (Mair, 1969, p188). In fact amongst the Yao of Nyasaland the belief is that witches operate only against their own matrilineal kin, a relationship which is supposed to be harmonious. Hence Mair (1969, pp188-191) says that frequently where family members amongst the Yao purport to like each other, they in fact do not.

According to Mair (1969, p198), the Nupe of Northern Nigeria believe that female witches are more dangerous than male witches; Ngqila (2002), too, highlights the female aspect of the witchcraft allegation amongst the Tafeni, where clashes between mothers-in-law and daughters-in-law are so intense that the older woman is invariably accused of witchcraft.

Since *ukuhanjwa* is aligned with the acts of familiars owned by witches (i*zilwane zamagqwirha*), it is important to explore the conceptualisation of witchcraft in relation to illnesses and health amongst the Southern *Nguni* people, who are the focus of this study. Amongst the Southern *Nguni* people, as amongst most people in traditional non-Western cultures, witchcraft is seen as the efficient cause of most misfortunes including ill-health. In cases where the diviner ascribes the misfortune to a withdrawal of protection by ancestors, witchcraft would still be seen as the efficient cause, while withdrawal of ancestral protection would the root cause. Every time illness strikes, the common occurrence would be for traditional people to think of possible enemies who would want to harm them, rather than of naturalistic causes for the illness. This is as a result of socialisation from childhood. The socialisation of those who have always been immersed in traditional African thinking would be different from that of persons who became exposed to Western thinking at some stage. For those exposed to Western values and thinking for a prolonged period of time, there might be a certain amount of questioning before certain cultural practices are engaged in. Hence Eastman (2011, p190) says that meanings attached to illness causation and experiences will differ from person to person, but for this study, perceptions assumed by the majority of the culture will be assumed to be the dominant perceptions.

Foster (2009, p114), in his research among the *Bomvana* people, in the Eastern Cape focused on instruments or techniques used to cause illness, such as the intrusion of an object, theft of the soul (*ukwebiwa* in *isiZulu*), spirit possession and witchcraft – although witches could be behind all of these techniques. *Ukwebiwa* is a name used by the *Zulu* people for the *ukuhanjwa,* and as the Zulus also belong to the *Nguni* group, the implication is that the findings for the *Bomvana* people could also apply to the Southern *Nguni* – and vice versa.

Foster (2009, p116) states that people suffering from spiritually-caused illnesses are considered blameless, with no control over their condition. In this regard, he asserts that amongst the *Bomvana* there are no absolute rules to avoid arousing the envy of others, or prescriptions regarding the quantity of rituals required to satisfy the ancestors. In many cases the victim - especially when it is a child – is thought to have come into contact with an evil spirit which was not intended for him or her. This is possible because it is believed that familiars do not always act under the authority of witches – they may act independently. Thus a person may become ill without having experienced enmity with anyone. Foster (2009, p116) recognises three levels of illness causation; the witch or sorcerer as the efficient cause of the illness, the spiritual techniques as the immediate cause of the illness, and the ancestors who are not the cause of illness but would withdraw their protection from a person so that he/she falls victim to the witch or sorcerer (Foster, 2009, p114). Honduras Peck (1968, p78) in Foster (2009, p114) regards ancestors' withdrawal of protection as the third level of causality; the final or ultimate cause for the illness, as an attempt to answer the question, "Why did this happen to me at this time?"

Hart (1978, p74) has a different proposal from that of Foster (2009, p116) and suggests that spiritual agents would be the efficient cause of illness, spiritual penetration would be the instrumental or immediate cause of illness and the witches and sorcerers would be the ultimate cause of illness. The belief amongst traditional African people is that ancestors are there to protect their living relatives from harm, as long as they respect and honour the values and norms socially constructed by their ancestors. Should they deviate from them, ancestors will withdraw

their protection. As Foster has indicated, this has always been seen as the ultimate cause of illnesses or misfortunes.

A question that arises is, "How does one recognise that he/she is a victim of witchcraft?" Mair (1969, 185) asserts that belief in witches is a fundamental part of the worldview of the people he studied in Africa, hence it is a matter of course to attribute illnesses to witchcraft; little concrete evidence according to the Western worldview is ever required. That has always been the mistake of those who subscribe to the Western worldview; they measure other worldviews against their own. They simply do not acknowledge the reality of the alternative worldview. From the African perspective, witchcraft is evidence-based, in that witches are known to have confessed about their acts of witchcraft and people have witnessed witches in their acts of witchcraft. The idea that witchcraft is an evidence-based theory has yet to be acknowledged in the literature. Mair further concludes that the belief in witchcraft exists amongst people with little knowledge of scientific causation and as a result would not recognise the possibility of the accidental conjunction of causal factors called chance. However, the theory of cultural modernities shows that even amongst urban people who have knowledge about 'scientific causations' of illness and death, belief in witchcraft remains. This has been confirmed by a South African anthropologist, Marwick, who says in Mair (1969, p200) that witchcraft plays a part in all the new competitive relationships that arise in modern life; it is still seen as a means to resolve interpersonal conflicts and to acquire, retain and express power wherever any form of competition is manifest.

According to Afolayan (2004, p68) the concept of change has very minimal application in the Bantu worldview. In other words, even educated and urban people continue with their pluralistic

behaviours when it comes to health systems, believing that modern medicine deals with the physical, while traditional medicine deals with the spiritual. It is this pluralism that leaves some who straddle both worlds to wonder, sometimes, which health system to credit when healing occurs.

Foster (2009, p115) found out that among the *Bomvana* people of the Eastern Cape, their immediate concern when a person is ill is, "Who is responsible?' Among the people of Mali, the major concern would be "Why am I ill?" and in this regard the next question would be, "What ancestors are angry at me, and why?" Following this, they would want to know who is responsible. The reason for this sequence of questions is that African people believe that ancestors are there to protect and guide them. Once a person falls ill, it is assumed that the ancestors have withdrawn protection. Before the road to healing can even begin, there would be a need to restore favour with the ancestors. Without ancestral protection, they believe that they are easy prey to witches and other evil forces, resulting in ill-health and other misfortunes. Thus they need to appease ancestors first, and attend to the 'who and why' questions afterwards. Similarly, the Lugbara of the Nile-Congo border in Mair (1969, p194) believe that God created the world, but ancestors prescribed customs – hence breaching customs results in ancestors' anger. In this way, social order and control is maintained. Thus when family members have breached religious or kinship obligations, ancestors withdraw support. They are not originators of evil (Afolayan, 2004, p68).

Uncovering the cause of illness might appear time consuming and demanding, from the biomedical perspective. Subscribers to the biomedical system might even blame the traditional

route for delaying the process of healing and causing a person's death. But with traditional people (indigenous, indigenized and modernised people who still use indigenous healing), healing carries greater connotations than merely physical, and the methods used for healing must address the issue of harmony and balance within the individual, family, community and environment. To them, health begins with a good relationship with ancestors. Once this relationship is restored, they look for answers as to the 'who' and 'why'. Foster (2009, p115) refers to these cultural illnesses as 'personalistic' illnesses, with multiple levels of causation, which require healers with supernatural or magical healing skills. Eastman says that naturalistic illnesses are also acknowledged.

For Southern *Nguni* people, the main concern is 'what' has caused *ukuhanjwa*, meaning the familiars, more than 'who' has caused it. Once a familiar is suspected, they are quickly able to confirm or refute this suspicion based on the symptoms, and then to identify the healing method, that is, whether to treat the condition using plants at home, or whether to consult a diviner. For them, the 'who' and the 'why' questions can be asked at a later stage or at all, since *ukuhanjwa* is not blamed on witches, but rather on the random acts of their familiars.

2.4. The influence of culture in determining the healing methods to be utilised

Traditional medicines have existed as long as cultures have been around and will seemingly continue to exist in the future. According to Truter (*op. cit.*), 70-80% of the population in Africa utilises traditional (indigenous and indigenised) medicine, and about 60-80% of South Africans consult traditional healers or use traditional medicine before going to primary healthcare centres (Truter, 2007, p56). That is, they have a pluralistic stance towards healthcare. The findings also

place home deliveries of babies by traditional birth attendants at about 60%. This has been confirmed by Ngqila (2002) in the women of Tafeni location at Nyandeni Local Municipality of the Eastern Cape in South Africa who opted to give birth at home, without help, as a result of their overwhelming fear of witches and pollution, which in their view may lead to death. Truter (2007, p56) reviews the choices people make when seeking help for illness, and suggests reasons why South Africans continue to use traditional medicine even in this era of globalisation:

> The healer studies the patient as a whole and does not split the body and mind into separate entities. The healer never considers the patient as an isolated individual but as an integral component of a family and a community.

One cannot over-emphasize this aspect of African traditional healing. African healing is intertwined with cultural and religious beliefs and is holistic in nature, as it does not only focus on the physical condition of an individual only, but also on the psychological, spiritual and social aspects of the individual, family and community (Truter, 2007, p56). Patients trust traditional healing methods because they feel convinced that they and their symptoms will be taken seriously. They will be given time and a listening ear to express their fears (Truter 2007, p57 and Mpono, 2010). Thus it reaches to the deeper parts of a person, not only in its theoretical underpinnings but in its practical application too.

In support of Truter and Mpono, Winkler *et al* (2010, pp162-170), in their research on healing epilepsy, found that the majority of the people of Northern Tanzania strongly believe in traditional healing methods, especially those who are directly affected by epilepsy. Some people believe in both traditional and religious faith healing, as they see both of these as equipped to repel evil spirits and familiars (Sandlana and Mtetwa, 2008, pp119-131). Sobiecki (2008, pp333-

351) reported on personal experience and the experiences of other researchers on the effect of using certain traditional medicines from diviners, and found the claims to be true.

From the biomedical perspective such claims are relegated to the grey area known as theological or metaphysical healing. These terms simply means that the illness and its cure are credited to some supernatural entity without recourse to the scientifically identified regularities of positivism (Anderson, 1996, pp23-29).

Attention has been drawn by one of the researchers to the symbolic aspect of medicine where one may anticipate a philosophical reconsideration of medicine, and take a different direction from that of the rigid biomedical system (Kleinman, 2010, pp88-89). This symbolic aspect of medicine has to be taken into consideration when reading Anderson (1996, pp23-29) on metaphysical healing for theological illnesses, as defined by Western culture. These are so defined because empirical tests for these forms of healing have not been conducted according to Western biomedical standards. Anderson points out that even within the biomedical system certain processes are accepted as reality without there being any empirical evidence (Anderson, 1996, pp23-29). The example is given of the belief that the body gets rid of toxic substances and undertakes repairs as part of its nature. There is in fact no empirical evidence to back this up and so it may be classified under the theological-metaphysical paradigm.

Those who adhere to the traditional approach came to their conclusions after extended periods of observation and experience. They may not apply the Western biomedical processes of empirical tests, but according to their worldview and their reasoning, evidence - including that of

successful healing - is sufficient to inform them that their diagnoses are true and their methods effective.

Cocks and Møller (2002, pp387-397) embarked on research with the intention of finding out the motivations of consumers of indigenous medicine among *amaXhosa* living close to Grahamstown in the Eastern Cape. The *amaXhosa* are a subgroup of the Southern *Nguni* people. They found that frequently, patients would not consult with traditional healers but would consult people with knowledge in the area of traditional medicine, who would advise them where to find the plants required for healing and thereafter they would administer the plant on their own. It is the same situation with *ukuhanjwa* among the Southern *Nguni*. Not all the forms of *ukuhanjwa* demand consultation with a traditional healer. Some can be managed with plants at home (mild *ukuhanjwa*) while others do require a consultation with a healer (severe *ukuhanjwa*). Cocks and Møller (2002) found out that good health, according to *amaXhosa*, is holistic and inclusive of the person's social environment. They came up with three categories of traditional medicines; those used to enhance personal well-being, those used for cultural purposes, and those used to treat physical conditions (diseases), whether spiritually-caused or naturally caused. In this regard, one would perhaps categorize *ukuhanjwa* under conditions which require medicines for personal well-being, as well as medicines for spiritually-caused illnesses. Medicines for personal well-being, as described by Cocks and Møller (2002), would include those which are used to protect people from evil spirits.

Smith-Oka (2012, p11) mentioned the concepts of 'hot-cold' and 'wet-dry' as being used by the Mesoamericans when referring to indigenous health and illnesses. Illnesses which are

categorised as ‘hot’ are treated with ‘cold’ medicine and illnesses which are said to be ‘cold’ are treated with ‘hot’ medicines. The same applies with the ‘dry’ illnesses which are treated with ‘wet’ medicine and ‘wet’ illnesses treated with ‘dry’ medicine. This does not refer to the actual condition of the illness or medicine, but rather refers to “characteristics of their temporal nature” (Smith-Oka, 2012, p11). The description of a condition as ‘hot/cold’ or ‘wet/dry’ seems to be symbolic and ritualistic rather than literal, and thus is not understood by those who subscribe to the biomedical health system. With traditional healing methods, the colour of the medicine, the time of its harvesting, the place of healing as well as the presentation of the medicine and healing method have a significant connection to the source of the healing power (Washington, 2010, pp24-39).

Kirsten, Van der Walt and Viljoen (2009, p1) have acknowledged the fact that modern Western medicine is “not consistent with the systems view of nature and the conception of illness as a consequence of disharmony and imbalance”, as proposed by not only African traditional healing but also by many alternative health systems within the European tradition, such as homeopathy and naturalism. It becomes impossible to even compare the biomedical and the traditional healthcare system. Foster (2009, p110) asserts that they are based on completely different ideas of what causes illness – that is, ‘from spirits to germs’.

Research conducted by Ayibor (2008) in Johannesburg focused on the treatment received by children who visited traditional healers. In his findings, 70% were treated for either *inyoni* (sunken anterior fontanel) or *ibala* (capillary *naevus*). Oral herbal preparations were given to rub onto the anterior fontanel of the child, scarification (cuts or incisions) was done and talisman or

amulets were given for protection. But there was no mention of how these prescriptions were arrived at. The mention of the illnesses gives one a clue as to reason for these prescriptions; *inyoni* is believed to be manifestation of *ukuhanjwa* by the Southern *Nguni* peoples of South Africa, and is seen therefore as a spiritual attack requiring certain spiritual processes. But Ayibor does not go into the perceived cause of the illnesses presented. Amongst the Southern *Nguni*, certain illnesses lead to suspicion and blame being laid on acts of witchcraft by family or community members, resulting in mistrust and cracks in relationships. This implies that disturbances in social equilibrium take place even if health is restored using traditional medicine or alternative means of healing.

2.4.1. Discovery of traditional healing methods and medicines

According to Patil (2011, pp25-29) traditional medicines have their origin in observations of animal behaviour, accidental or incidental experiences of trial and error (what Eastman calls experimentations and guess work, Eastman 2011, p188), the divine knowledge of seers (their dreams, according to Eastman (2011, p188) and the doctrine of "divine signature". The doctrine of divine signature, as described by Patil (*op. cit.*)), is the belief that God embeds his signature into his creation; that plants and other aspects of nature carry aspects of his power, wisdom and ability to restore. Oken (2005) has the understanding that a spiritual framework guides most traditional people as to which healing method to use. The Southern *Nguni* cosmology holds that ancestors guide and protect them, and thus it is not surprising to find that ancestors are believed to be intimately involved with individuals on a day-to-day basis, guiding those who need healing to the exact type and location of plant needed. Levine (2012, p66) says that any member of society can collect these traditional medicinal plants, which are believed to be more powerful

when found growing wild than when domesticated. This makes no sense to those who subscribe to the biomedical systems of health as the explanation would be outside of their scope of understanding.

Diviners impart their knowledge to herbalists, who start out as diviners' assistants, and later graduate as independent herbalists with an in-depth knowledge of plants and their healing properties. There are of course those who put themselves forward as both diviners and herbalists who know very little about healing, and it can be difficult for some people to differentiate between the "bona fide traditional healer and a charlatan" (Eastman, 2011, pp188-189). The tried and tested method for discerning the genuine healer has always been the evidence of his power to heal; thus, word of mouth. The only training herbalists receive is at the feet of the diviner they assist. Over a period of years they learn to know plants in detail; when to collect plants, what features to look for, how to prepare the plants, how to perform the necessary rituals, the various locations for performing various rituals and any other aspect they might need to know in order to heal a person using plants.

As well as plants, one cannot overlook the use of household products for 'indigenised' healing. These products are known as Dutch remedies. Some of the most popular Dutch medicines which have been indigenised are the haarlemensis, stuipdruppels and doepa (Friend-du Preez, Cameron and Griffiths, 2009, pp345-350). According to these authors, Haarlemensis is mixed with Vaseline and doepa as a smoke. They state that these Dutch medicines are used mostly for the protection of babies against evil spirits, and against witches who might wish to harm them. The method is to add a few drops of the remedy to the baby's bath, and to its milk, and to rub onto

the baby's fontanel. The authors further mention "socially constructed" medicines using household products such as Sunlight soap (although most people prefer using blue soap), and the 'original' white Colgate toothpaste which is known to contain baking soda, and is used for rashes and acne. The authors' understanding is that the 'original' white Colgate toothpaste has no abrasive agents or irritants such as hydrogen peroxide and is traditionally used for an illness called *isilonda* (another name used for *ukuhanjwa*) although the details on how it is used has not been divulged by these authors. Research for this study does bring to light its use and method of application, as will be seen in Chapter 5.

2.4.2. Major factors promoting the use of traditional healing methods

One of the chief reasons people practise any behaviour is in order to achieve a sense of belonging; of not standing out amongst their social group. The continued use of indigenous medicines may be ascribed largely to the desire among users to demonstrate respect for, and a sense of belonging with, one's culture and one's people. Belief in one's family's ways and the ways of a husband's family may directly influence an individual's choice of healing methods as a result of this desire to belong (Friend-du Preez, Cameron and Griffiths, 2009, p345). Through socialisation, people develop an attachment to the values and norms of the family and community. Breaching them would be disturbing the equilibrium of the whole environment, which includes not only family and community, but ancestors too.

The common reason why parents take their children to traditional healers, as mentioned by Friend-du Preez, Cameron and Griffiths (2009, p345), Truter (2007, p60) and Ross (2010, p47) is to protect them against evil spirits or familiars, and to rid them of these should they be

believed to have come into contact with the child. It is here where the Western biomedical system and traditional methods diverge. The concept of evil spirits has no meaning to the Western biomedical system, yet it is inextricably woven into and a part of the worldview of most indigenous African people. The continued use of traditional medicines in the face of the overwhelming dominance of the Western biomedical health system, and in face of government policy, indicates cultural resilience and could be seen as a form of defiance. All governments wish to show themselves as advanced and able to provide the best quality services to their people; it is inevitable therefore that they promote the Western biomedical health system and urge their people to use these services. The continued use of traditional healing in the face of continued pressure to choose Western methods is recognised by governments including the South African government, and attempts have been made to accommodate the traditional system within the overarching framework of legislation, but it is an uneasy compromise. Legislation can never completely cover traditional methods, as they deal with elements that cannot be quantified or audited using Western modernity.

Friend-du Preez, Cameron and Griffiths (2009, p345), Truter (2007, p60) and Ross (2010, p47) also listed availability of services as a factor which impacts upon people's continued use of these services. Traditional healers are open at almost all hours, and their medicines are either dispensed by the healer himself or herself, or they are readily available in nature or as common household products. For instance, traditional healers claim the ability to cure every disease and to treat every situation that threatens man in his daily life. Their claim is based on the fact that they are well acquainted with the needs, aspirations and desires of their fellowmen. There is a deep-

rooted belief that certain diseases cannot be cured by physicians. The people often speak of *izifo zesintu* (sicknesses of the people's way of life).

By contrast, biomedical health centres are far from rural people's homes, they experience shortages of staff and of medicines and they often involve long hours spent queuing. In addition, the same authors indicated that nurses are often short-tempered as a result of overwhelming numbers, and people may be made to feel inadequate and inferior. When it comes to *abantu* illnesses, few people would choose to undergo all of this for what is inevitably going to be an inadequate, incomplete or wrong diagnosis according to their perception. These centres are not equipped to deal with *abantu* illnesses. Even if the biomedical health centres were open 24 hours a day, African people would still opt for traditional healing methods for what they believe to be *abantu* illnesses as their belief is that these illnesses are spiritually caused and 'medically invisible' to the biomedical means of diagnosis. The same would apply for warding off pollution and repelling evil spirits. African people believe in the existence of these phenomena and the Western worldview has no place for them at all.

The issue of trust and efficacy is apparent and central to people's choices of healing method. If a traditional healer or a home remedy successfully healed a neighbour's child, people are more likely to be drawn to the same method because they know and trust the person who informed them of this. On the other hand, people are offended when biomedical health centres simply give their children Panado – trade name (Paracetamol / acetaminophen – generic name) or their children for what they regard as a serious *abantu* child illness.

Friend-du Preez, Cameron and Griffiths, Truter and Ross expand on the issue of people' negative experiences with nurses and doctors in biomedical health centres. Patients, they say, are frequently chastised for using traditional remedies for first aid. Patients also incur nurses' reprimands for not closely following instructions when administering biomedicines. The two systems clearly come into open conflict and it is in the interactions with nurses that this is felt the most. Many conflicts arise because people are simply trying to deal with the spiritual aspect of the illness on their own, knowing that they will not get help for this aspect at the hospital. Moreover, when it comes to adhering to protocols for administering medicines, people naturally tend to practise what they would do with traditional medicines, where dosage measurements and precise times are not as crucial. Most of all, however, it is the very existence of *abantu* or cultural illnesses which are behind the adherence to traditional methods; biomedical health centres are not equipped to address these.

2.4.3. Shortcomings of traditional healing methods

One of the obvious shortcomings of traditional healing is that no written records are kept of the plants and methods used. All of the knowledge is handed down by word of mouth. This poses a threat to the continued existence of the system of health, especially amongst the younger generation. In recent years younger people have lost out on the natural process of enculturation that traditionally takes place within families. As parents die, due to HIV/AIDS and other ills, and as tales told by grandmothers fade out, to be replaced by TV and other forms of entertainment, the process of learning cultural beliefs and ways is threatened. All of this results in a loss of specific knowledge.

In addition, the rising affluence of people has made many who can now afford biomedical treatment from private doctors opt for this as their preferred treatment, according to Pushpangadan and George (2010, p11) although their claim cannot be confirmed within African communities as it has already been highlighted that many educated and affluent people are using traditional medicines secretly and simply withhold this knowledge from biomedical practitioners. Considering the secrecy with which educated people use traditional healing methods, it is possible that the claim of the above authors has no substance. Ross (2010, p48) confirms this secrecy. Pushpangadan and George (2010, p11) point out that the government has realised the value attached to people's beliefs and use of traditional healing methods, and that attempts have been made to at least recognise and protect valuable streams of indigenous knowledge.

The issue of lack of hygiene in the practice of indigenous methods has been highlighted by Pushpangadan and George (2010, p11), who identify un-sterilised utensils used by traditional healers and caregivers as a threat to people' health. Ngqila (2002) has raised the issue of ritual cleanliness, and how this is considered of greater importance than physical cleanliness prescribed by Western biomedical doctors. What could be viewed as unhygienic by one culture could be contextualised as ritually clean by another culture. An example could be made of a situation whereby *umqungu* grass (*Andropogon marginatus*) is used by the Southern *Nguni* people of Nyandeni Local Municipality in the Eastern Cape Province of South Africa for cutting the umbilical cord after childbirth as mentioned by Ngqila (2002). The grass would be first washed in what would be understood as clean water in a rural situation before it is used for cutting the umbilical cord. Their reason for avoiding a sharp, steel object to cut with is that they wish to disassociate sharp, steel objects from the child - they want to prevent the child from being

harmed or harming others with sharp, steel objects when he or she grows up. In addition to that, Southern *Nguni* people link grass with their ancestors, as the grass is food for cattle who inhabit the cattle byre, which is believed to be the abode of the ancestors. Hence it is ritually clean.

One can also bring in arguments by Douglas (2010, pp9-10) on issues of ritual purity and the linguistic discourse regarding the contextual meaning of ritual purity. It is clear that according to Douglas (2010, pp9-10), there is distinct difference between ritual purity and hygienic cleanliness where, according to Western thinking, purity is equated with hygienic cleanliness. Cleanliness is interpreted differently by traditionalists using ritual performances and healing – hence the existing tension between the biomedical and traditional sectors regarding diagnostic and healing procedures.

The concurrent use of biomedicine and traditional medicines, according to the above-mentioned authors, is viewed as a shortcoming of traditional healing, as it is believed that it has a deleterious effect on the process of healing offered by biomedicine. Ross (2010, p48) recognises that it can be difficult to measure the effects of these pluralistic tendencies, because one would not know whether a patient has used traditional medicine or not at the time of administering the biomedicine. Without full disclosure by the patient, doctors would have no way of knowing whether the traditional medicine is interfering with the bio medically-prescribed medicine or not. As long as people believe in spiritually-caused illnesses they are unlikely to stop using traditional methods, and it is likely that their continued use while simultaneously using biomedical medicines is more common than doctors realise.

The above authors also highlight that mothers and caregivers are frequently warned at the biomedical health centres not to use the 'Dutch' medicines on babies, as they suppress the respiratory centre of the child causing the baby to wheeze. Most Dutch remedies were originally intended for adult use, not babies. Here one thinks of haarlemensis, doepa and others which are usually mixed with a baby's Vaseline to repel evil spirits. These are medicines indigenised by the Southern *Nguni* people as a result of their very strong smell, which is somewhat akin to the smell of the plant traditionally used for repelling evil spirits, i.e., *iboza* (*Plectranthus barbatus*) and *isivumbampunzi* (*Tulbaghia violacea)*.

Holmes (2010, p402) states that she would like to read more research that is critical of traditional medicines because she believes that their supposed negative effects could be exaggerated. All healing methods, she argues, have shortcomings and strengths, and there are moments of failure and success for all systems. Indeed, it would not be a fair practice to compare the two healing methods, as they originate from two completely different worldviews and cosmologies. Holmes (2010, p401) continues to make an interesting argument by stating that people who survive best are those with firmly held beliefs and ideologies. Her understanding is that it is not religion as such that saves people, but it is their sense of community and of connection, and their ideology's ability to help them place their suffering in a wider context. Different cultures may express their beliefs in supernatural healing in different ways and yet it seems that many cultures believe in a power greater than themselves which is able to repel illness – whether that is expressed as God working through ancestors to repel familiars, or God directly healing them by his Holy Spirit – or variations on this idea.

Given that no culture is static, it is possible that traditional health systems have undergone an evolution just as Western ethnomedicine has evolved. It is possible that though both are evolving, they are not moving in the same direction and pace, since both originate from different worldviews. According to Mofokeng (2003, pp14-15) "bringing in things to enrich the existing culture" could contribute towards the evolution of ethnomedicine of a particular society. The question could be how much power biomedicine has to influence and enhance other ethno medicines as they develop. Taylor (2001, pp1-9) and Eisenstadt (2000, pp1-29) state that biomedicine should be viewed as Western modernity, something which cannot be equated to pure modernity. The general assumption made was that traditional medicines, which are viewed to be inferior, should and will evolve in the direction of biomedicine which is superior and will eventually dominate the whole world.

2.4.4. The pluralistic nature of help-seeking

As has been mentioned before, there are illnesses which can be healed by biomedical practitioners using biomedical healing methods and there are those which are believed to be medically invisible to biomedical practitioners and require traditional healers using traditional medicines. Many people invariably use both methods - a phenomenon known as the pluralistic approach to health care. Karnyski (2009, p1) reported that this approach is used by the Rathwa of Kadipani and Kawant villages. In South Africa, Ross (2010, p46) reported that for every ten black African people, eight rely on traditional medicine alone or combine it with biomedicine, a practice she refers to as medical pluralism or medical syncretism. This pluralistic nature in healing has also been observed by Thinwa (2004) with Tuberculosis (TB) and HIV/TB patients where about 70% are practising traditional alongside biomedical healing, as they believe that

either an evil spirit might take advantage of the situation or an evil spirit has caused it and must be repelled. Most studies in India show that Indians, too, take the pluralistic approach (Bhana, 1986, p221). According to this author, for most mental illnesses, Indians consult a traditional healer before consulting with the biomedical system, a pattern of behaviour that is confirmed by Mascie-Taylor (1993, p18). Indians would also continue using traditional medicine alongside biomedical medicines. According to Bhana (1986, p221), this is usually because neither the traditional healer nor the biomedical centre give a clear and straightforward diagnosis – therefore the patient's family would be unable to eliminate either system.

With regard to mental illness in African societies it is a little different, as mental illness is regarded very definitely as an *abantu* illness, requiring a spiritual solution. According to the African worldview there is no physiological explanation for mental illness, hence they would consult with a diviner, who would consult the ancestors for answers.

The Chinese have established that the same illness or disease can be successfully treated with different methods of healing (Hu, Du, Shen and Xu, 2012, p2) depending on the socialisation and environment of the ill person. It has been reported globally that for treating cancer, traditional Chinese medicine works very well in conjunction with biomedicine (Hu, Du, Shen and Xu, 2012, p2).

In Japan, the pluralistic approach flourishes. According to Ohnuki-Tierney (1984, p3) in Baer (2011, pp409-410), the medical pluralism of traditional Japanese people is displayed in their logico-meaningful structure of culture and in their religious institutions.

Amongst the Shona people of Zimbabwe, too, there are beliefs in spiritual, socio-moral and natural illnesses (Shoko, 2011, 290) and indigenous religion is known to be practised amongst the urban population. They use both biomedical and home remedies (indigenous and indigenised), including the use of household products.

In South Africa we find that more and more there is an informal healing model generated by the emergent black middle class, who depend on both biomedical health systems and traditional health systems, in a two-stage process. It would be common for such people to start with the biomedical system and later to use the traditional system of health care (Farrand, 1984, p2). According to Farrand, these urban people would visit a biomedical health centre for healing the illness, and use the traditional system to determine the cause of the illness. In academic terms, this group of urban people perceive biomedicine as adequate to heal the physical, but not to determine the ultimate or instrumental cause of the illness. Hence they find it necessary to use traditional medicine to appease ancestors so that they are protected from further attacks.

Traditional faith healers are known to be cheaper than *amagqirha*/*izangoma* and *amaxhwele*/*inyanga* (diviners and herbalists respectively). These traditional faith healers are mostly found in the Afro-Christian/African Independent Churches (AIC), for example, the Zionist Christian Church (ZCC), as well as charismatic or salvation churches. These types of churches owe their power of attraction to their fundamental concern with health and well-being (Shoko, 2011, p290). This pluralistic habit is not only prominent with urban black people, but finds adherents in the rural areas too.

2.5. The Western culture of modernity and its empiricist paradigm

People of the west have a tendency of viewing other people's understandings of illness and healing as medical 'beliefs' and practices (Good, 2010, pp64-65). The terminology reflects the hierarchical assumption made by adherents of the Western biomedical approach. Good explains that in the Western system, when a person's complaints about health do not reflect a physiological cause, the condition is regarded as meaningless or at best a reflection of the person's beliefs or psychological state. This is an example of an ethnocentric perception. It has already been suggested by the theory of cultural modernities that there is no pure modernity; that instead a particular culture may be thought of as modernized. Thus biomedicine may be seen as the medicine of a modernised Western culture – hence, ethnomedicine. Good (2010, p67) refers to "rationality literature", which holds that witchcraft is a proposition and not factual, since it has questionable verifiability and its deductions are not valid. In this regard, Good is referring to verification and deductive validity according to the standards of Western culture and its empiricist behaviour and not that of the Azande people, who were the subject of his study.

The assumption that Western biomedicine is the standard for all medical systems is thus challenged on many fronts. There is a struggle between cultural beliefs. Good is also supported by Urbasch (2002, p5) who posits that biomedicine uses "science as an ideological counterpoint to their power and influence". Science is seen by Western biomedical practitioners as justifying their disregard of other medical systems, which may well have a more complete awareness of the human condition.

Biomedical and indigenous methods of diagnosis do not follow the same processes and procedures to diagnose illness, since they operate from totally different points of departure, that is, the germ for biomedicine, and the spirit for traditional healing methods. Urbasch (2002, p11) finds similarities between the Asian and African systems, with both of these people groups regarding the human being as an integrated whole within the total ecology of the environment. In both of these continents (and to which one may add the continents of Australia and the Americas) indigenous people take cognisance of the interrelated spiritual, magical and mystical forces which surround the individual. Hence they find it within reason to blame spiritual, magical or mystical forces for ill-health when evidence supports this, as defined by their own worldview.

Truter (2007, pp56-60) finds that culture and religious beliefs are intertwined, hence the involvement of supernatural beliefs in the aetiology of illness and in the management of certain illnesses - those categorised as theological by Anderson (1996, pp23-29). Urbasch (2002, p11) similarly states that people from Asia and Africa view mental and physical health as essentially intertwined with religious, social, cultural and moral concerns. This literally means that these cultural groups view health from a holistic point of view. Health is found when balance or equilibrium is established between a healthy body and a healthy situation or environment surrounding that body.

Traditional healing allows consideration for a variety of causes of illness as suggested by Urbasch (2002, p11). He explains that the reason for the significance of traditional healing is that spiritually-caused illnesses (*ukufa kwabantu*) may be seen as the result of a variety of causes, including witchcraft, omissions or transgressions by the individual, or his family, or an ancestor,

pollution (*isimnyama*) or spirit possession. All are examined and all are possibly relevant to the ill-health of an individual.

When possible acts of witchcraft are mentioned by patients, it is confounding for biomedical health practitioners, according to Mair (1969, p186), since, apart from simply disbelieving in the existence of witches, biomedical practitioners cannot establish who this person is. Indeed, the patient frequently cannot, either. Witches are thought of as secretive and employing many means which cannot be observed by the human eye. The biomedical system seeks empirical and scientific evidence. When adherents of traditional medicine claim that witches have in fact confessed, thus proving their existence, biomedical practitioners have no frame of reference with which to assess this, and simply dismiss such confessions as mental illness.

Pushpangadan and George (2010, p12), in their report on mother and childcare among the rural and tribal Indian populations, put forward a significant argument for the efficacy of traditional medicine. They argue that one cannot seek to comprehend traditional medicines using the tools of modern science, and that the underlying truth in these systems is to be found in their survival over millennia, which is evidence enough that they work. They encourage the recognition of traditional healers and "time tested" ethnomedical practices, which remain important even in this era of high technology and globalisation. They further state that traditional systems should not be subject to the kinds of tests one would expect in the biomedical health system, as traditional and biomedical systems operate from totally different worldviews. The biomedical system seeks to address and impact upon the physical systems of the body, while traditional medicines seek to

address and impact upon the spiritual causes of illness. The existence or non-existence of these causes cannot be measured using Western, biologically-based means.

It is a matter of some perplexity to Western people that other cultures demonstrate resistance to the dominant, Western health care system by engaging in dual or multiple modernities. Adherents do not see the traditional health care system as belonging in the past, but as being modern, but culturally based. The assumption by Western people that these systems will evolve toward their own systems is an example of the cultural empiricism for which West has been sharply criticised before. The empiricist paradigm is so pronounced that it has given rise to reactions. Not least among these are theorists and social justice activists who advocate culturally congruent healthcare and who recognise traditional healing methods as adding value in the search for a healthy and balanced global society.

2.5.1. The effects of globalisation and the hegemonic tendencies of biomedicine on illness and health

It should be understood that globalisation has resulted in a diversity and not a uniformity of cultures, as highlighted by the cultural theory of modernities. This theory demonstrates how the apparent dominance of Western culture has not resulted in the abandonment of different cultural practices. Instead we find various cultural modernities as explained in the theoretical framework. Long (1996, p39) asserts that, despite the assumption that the technological and information revolutions would make the world more uniform, instead cultural, ethnic, economic and political diversity has flourished. Schott and Henley (1996, p17) also point out the assumption amongst Western people that when people have access to Western medical care they automatically

abandon their traditional health systems – an assumption which has been proven to be incorrect. Instead, globalisation has generated new diversified patterns of responses, giving rise to the cultural theory of modernities, and the pluralistic approach by people towards healthcare.

It is also often assumed that people in rural areas continue to use healing methods only because of limited access to biomedical centres. But this is disputed by Gordon (2010, pp165-183) who states that the *Xhosa* people submit to using biomedical healing methods without giving up their belief in the powers of their traditional healers and medicines.

According to Mafimisebi and Oguntade (2010, p2-9), both traditional medicine and biomedicine share a common goal – healing and prevention of illness - but part ways when it comes to causes and healing methods. It is often claimed that people who use traditional medicines are those who are illiterate or poorly educated. However this is repeatedly found not to be the case – highly educated people may retain a traditionalist viewpoint. In fact it is often the more educated who realise what Western cultural empiricism has done to the morale of indigenous cultures, who understand its link with political oppression and various social problems experienced today, and who therefore take a strong stance in "returning to their roots". Highly educated people are frequently the strongest traditionalists. Certainly, as long as people continue to believe that there is a spirit world and spiritually-caused illnesses, urban, rural, literate and illiterate people will continue to use traditional healing methods. This includes traditional healers, herbalists, home remedies using household products and faith healing.

The use of biomedical healing methods has always been associated with reason and rationality, which are viewed as the source of progress in terms of knowledge and society (Barker, 2003, p45). But in terms of truthfulness and falsity of knowledge in medicine, or in any other area of life, Barker (*op. cit.*) states that knowledge is a matter of perspective, not pure or neutral. It is always attained from a particular point of view. Hence the claim that truth can be viewed as a social commendation rather than an accurate picture of an independent reality, stemming from cultural pluralism as a way of generating shared meanings by different cultural groups (Barker, 2003, pp51-60). This conflicts with the biomedical view of itself as representing absolute truth based on empirical evidence. Traditional people have their own means of testing the validity of their diagnoses, discussed more deeply in chapters 5 and 6 under traditional evidence-based theories.

Interestingly, traditional ethnomedicine has led to the development of several new drugs based on plants that were in use years before Western biomedicine discovered them. This has led to the "genesis of medicine from nature to laboratory" (Patil, 2011, pp25-29). Biomedicine in fact makes great use of medicinal plants from all over the world; they are simply packaged, marketed and understood differently.

Lans (2006) suggests that the relationship between biomedicine and traditional medicine can be understood within the framework of two fundamental concepts, that is, the concept of structural superiority and functional strength. Western biomedicine has acquired structural superiority or elite status because of its acclaimed ability to control diseases and suppress symptoms, resulting in its hegemonic tendencies. Folk medicinal systems retain 'functional strength' because of their

accessibility to people living in isolated communities in rural areas. Anderson (1996, p109), in support of Long's argument, mentions the existence of a "hierarchy of resort". According to this author, the expectation is often that people who have been influenced by global, Western-dominated culture would seek biomedical care first and traditional medicine only if they experience no recovery but, instead, the opposite is the case. The fact that people visit traditional healers as a first port of call refutes the idea that biomedical centres are avoided because of poverty or travelling distance; instead traditional healers are in fact the preference and often the only help sought, for what are perceived as spiritually-caused illnesses. The reality of the pluralistic nature has been observed by Varga and Veale (1997, pp911-924) who observed pregnant women mixing traditional medicine and clinical care.

Foster and Vilendrer (2009, pp1-7) observe the same trend in Tanzania where caregivers were noticed pursuing particular methods of healing for malaria in their children. The Tanzanian caregivers identified malaria as either uncomplicated or severe. According to the authors, uncomplicated malaria manifests as a fever and is not regarded as much of a threat. Caregivers would use biomedical healing methods to heal it. Severe malaria, on the other hand, was greatly feared because it manifests in the form of convulsions – and was hence associated with the spiritual diseases *dege* and *mchango*. These authors state that caregivers use traditional healers for convulsions, as they believe that they are spiritually-caused. According to Foster and Vilendrer (2009, pp1-7), traditional healers would even caution caregivers against the injections given to babies at hospitals in the belief that these may paralyse them. The possibility is that even if traditional healers were afforded the opportunity to explain their reasons for believing this, the explanation would be meaningless to those subscribing to a different worldview. It does not help

to assume that their claim is as a result of illiteracy or a lack of understanding of how biomedical facilities work. It is interesting that biomedical help, in this case, was considered adequate for the mild form of the sickness, but for the really serious condition of "severe malaria", a stronger and more effective remedy was sought, and only traditional methods were employed. This sort of choice, made repeatedly over generations, cannot be based on assumptions only, but on evidence of efficacy.

The authors further report on an aspect of collaboration between the two health systems in Tanga, Tanzania, where traditional healers co-operate with biomedical practitioners by encouraging people to visit these centres for diagnoses. One might conclude from this that the biomedical health system has succeeded in replacing the traditional health system in the area of diagnosis. However, one could also argue that traditional healers are co-operating so as to allow the biomedical centres an opportunity to exhaust all possibilities before they step in. It is in their favour for it to be known that patients have visited biomedical centres first, and failed to find a cure. It is then that they can claim credit for healing. The claim is often made by biomedical centres that visiting traditional healers first merely delays the process of healing. The same claim could be made by traditional healers – that visits to biomedical centres delay the correct diagnosis and the process of healing.

Gangadharan and Shankar (2007, pp181-184) state that in the process of globalisation, the reality of cultural pluralism has not been acknowledged. Globalism promotes a mono-cultural view of the world, but the reality is very different in almost all fields, including illness, healing and medicine. As a result most people resort to using traditional healthcare systems secretly prior to,

simultaneously or after biomedical healthcare. It has been mentioned before that the South African government established a Traditional Health Practitioners Act, No. 22 of 2007 (THPA), a Council and an Association for Traditional Healers (Moagi, 2009, pp116-126). These structures were meant to ensure that there was a regulatory framework which would include registration, and rules pertaining to the training and conduct of traditional practitioners. This was done as prescribed by Western cultural principles. However, most traditional healers are still outside of these structures as they depend on being guided by their ancestors in their practices.

In support of the arguments which have been raised on the negative effects of globalisation, Good (2010, p281) highlights the global tendency to market biomedical products, thus enforcing "the practice of clinical medicine in societies of scarcity". Yet poorer communities continue to experience inequalities in supply and distribution by these markets, as well as inequalities in access. A conclusion may be drawn from this global practice that the tendency to disregard the worldview of traditional people is influenced by the profit motive, as indicated by Good (*op. cit.*). Although this author feels strongly about the financial motive of biomedical health systems, one cannot deny their great contribution in healing and the prevention of illnesses. Latour in Good (2010, p273) argues that scientific work draws from and is influenced by cultures 'outside' science.

Sax (2011, pp3-5), Mafimisebi and Oguntade (2010, p2) have drawn our attention to the fact that all methods of healing are, in essence, ethnomedical, including the biomedical Western model. Culturally-based healing methods are relevant to the specific culture in which they arise; are

tailor-made, as it were, to their understanding of the world and of illness – and this includes the Western biomedical system.

According to Perret (2010), modern science does not have all the answers for illnesses. It remains sceptical of illnesses for which it has no frame of reference. This same scepticism is found amongst adherents of traditional medicine the world over, including those of Eastern Nicaragua, as explained by Wedel (2009, pp49-64) and, of course, the Southern *Nguni* people of the Eastern Cape, South Africa. Their world view, in their opinion, is more all-encompassing than that of the reason- and science-based Western world. Western medicine, it is acknowledged, is excellent at some things, but wholly inadequate for other things. Traditional people see all illnesses as real; they are not categorised as naturalistic and therefore real, and "metaphysical" and therefore unreal. According to their view, they have a far bigger and deeper grasp of the nature of reality than do those who insist on naturalistic explanations for phenomena, and therefore are better equipped to deal with certain illnesses.

When Farrand (1984, p779) conducted research on whether black patients would want traditional healers to work together with biomedical practitioners at hospitals, the majority responded that they would prefer to see their traditional healers privately at their homes. This could have been for several reasons; choosing one's own traditional healer, firstly, is considered part of the healing process, and secondly, there would be concerns about the authenticity of a healer in a hospital setting, who might come under the influence of Western practices. The connection with ancestors would also be doubted in such a setting. Lastly, it is also commonly believed that urban traditional healers are fakes. Farrand found that if they were to be established in hospitals,

people might see them, but then still consult their own healer in their home environment, thus rendering the hospital-based healer quite redundant (Farrand, 1984, p779). She further states since the West continues to uphold Western medicine (biomedicine) as the only acceptable form of healing, people would not feel comfortable consulting a traditional healer in this environment of condemnation and lack of acceptance.

Friend-du Preez, Cameron and Griffiths (2009, p350) advocate for biomedical practitioners, including nurses, to be trained in *abantu* illnesses and their traditional healing methods. Their argument is that, should these biomedical staff members show knowledge, recognition and respect for these beliefs and practices, they may be perceived as more approachable, thus putting to an end the secrecy surrounding these practices. These authors also realise a need to train traditional healers to recognise important signs and symptoms of childhood illnesses which require referral to a biomedical health centre. It is interesting to note that most rural people, including traditional healers, understand and acknowledge certain practices at biomedical centres to be essential – the drip, for instance. If traditional beliefs and practices were respected at hospitals, it is likely that greater co-operation would exist, and more traditional healers would insist that their patients see a biomedical doctor where, for instance, a patient needs to be placed on a drip.

2.5.2. The practice of culturally congruent healthcare

The reality of South African health care is that we have an exclusive system of health despite the legislative attempts by government to accommodate traditional systems of healthcare. Traditional healing practices, though widespread, are still practiced in secret. The pluralistic

approach of adhering to two healing modalities, the Western and the traditional, is well known, yet rarely would anyone admit this to a Western biomedical practitioner. The idea of harmonising the two healing methods seems to be an unrealistic dream, as long as one of them holds the dominant position. In such a case, the less dominant of the two would be inevitably subsumed by the stronger, and eventually disappear. The survival of traditional healthcare actually depends not on recognition by "officialdom" but on the continued adherence of those who strongly believe in keeping their identity and who do not scorn traditional ways. Such people are to be found amongst both the educated and uneducated, rural and urban.

2.5.3. Factors inhibiting the practice of culturally congruent healthcare

The question may be raised as to how cultural congruency within the healthcare system might look, were it to be adopted. One could adopt the British model as suggested by Baer (2011, p417), where traditional healing or alternative therapies and biomedical healing methods exist parallel to each other within the same physical space, tolerant of one another – an inclusive model. One could focus instead on achieving recognition by governments and by the population, a model labelled as the integrated model and practised in India and China by Baer (2011, p417). The American model is entirely mono-cultural and exclusive of everything not strictly biomedical – an exclusive model. Indeed, the American position reflects a narrow world view where everything not familiar is "dangerous and irrational" (Levine (2012, p66).

The same author proposes that traditional healing could be a relevant alternative for communities in remote rural areas with no access to adequate healthcare services – that is, biomedical centres. In light of the above statement, Levine (*op. cit.*), supported by Baer *et al.* (2003), Singer and

Baer (2007) and Fabrega (1997) in Baer (2011, 412), stated that the prestigious biomedical health centres are meant for the elite and the folk healers are meant for the subordinate segments of a society.

As is shown in this study, people who adhere to traditional cultural values and who choose traditional medicine may be found in urban centres, even though biomedical centres are within easy travelling distance. Their choices have nothing to do with being rural or urban, educated or uneducated, but reflect deep-seated beliefs about the nature of reality. Although the South African government has lifted the laws banning traditional medicine that existed under apartheid, there is still no parity between the two systems. The lifting of the laws may well have been a strategic political act, for an examination of the subject shows that no harmonisation is really possible between two worldviews that are so different. The practice of traditional medicine remains inhibited.

The inhibition of culturally congruent healthcare in South Africa began with the attitudes of the colonial powers who occupied South Africa. Various legislative Acts and policies against the use of traditional healing methods relegated it to the realm of the illegal and the inferior. Mofokeng (2003, pp15-16) sees this as ethnocentric behaviour. To some extent, the occupiers almost succeeded, for we find that many years later, people still find it difficult to confess to biomedical practitioners, including those of their own ethnicity, that they used traditional medicines before coming to the biomedical centre. As explained by Krige (n.d.) and Baer (2011, 417), the system recognised only Western medicine as authentic and authorised for all other practices to be banned and ignored. Of course, people continued to practise it, the law notwithstanding.

The schism was cemented by Sir George Grey, who established a hospital in King Williams Town in the Eastern Cape, hoping to transfer the responsibility of healing from what he regarded as 'rebellious and powerful' traditional healers (*amagqirha*) to European-trained doctors who would be loyal to the imperial authorities (Gordon, 2010, pp165-183). In the end Grey's plan failed as the belief in traditional health system is resilient and continues to this day.

In 2007, the Traditional Health Practitioners Act (THPA), No.22 of 2007 as an amendment of the THPA 35 of 2004 Act was passed, recognising traditional healers, and this was followed soon afterwards by the establishment of the Interim Traditional Health Practitioners Council (ITHPC) and the Traditional Healers Association which required members to pay a fee (Gordon, 2010, pp165-183 and Ross, 2010, p46). These structures quickly became bogged down in bureaucracy causing some traditional healers to refrain from joining. The issue of indigenising medicines using household products was omitted possibly because even the then colonial governments were not aware of such practices or they had no way of controlling them, as indeed was the case with traditional healers, who, though outlawed, could not really be controlled.

Simpson (1989, pp193-194) urged for the gap between the biomedical system and the traditional health system to be bridged. Her call came as a result of an observed rigidity in the biomedical system, which made no provision for home visits by hospital nurses in America. She saw this omission as having a negative impact on health care, as nurses remained ignorant of family belief systems. The old literature is an indication of the disparities which have always existed between

the biomedical and traditional health systems in every country and continue to exist to the present day.

One needs to note that even if Simpson's (1989) proposal had been taken up, it may not have had the desired effect, as people would have been unlikely to speak frankly to a representative of a medical system that discounts any views different from its own. Simpson highlights the need for constant links between biomedical systems and cultural systems of health care for a more complete understanding of the "other". Simpson (1989, p196):

> We live in a shrinking world. It is imperative that we understand our neighbours because the health of one affects the health of all. We as nurses can no longer hope our good intentions will automatically be communicated across cultural barriers; we must make sure that they are. We must learn about and appreciate the cultural heritage of the people we care for to deliver adequate health services in these modern times.

Simpson reached this conclusion after witnessing the refusal by a family of Mexican-Americans to allow surgery on their son, nor even to visit a hospital, after the need for surgery was made clear. The main issue in this regard is that various ethnic groups regard their own system as essential to their sense of well-being, just as the mainstream culture views itself as being central to the organisation and delivery of health care (Simpson, 1989, p193).

The biomedical health system feels the pressure of the continued existence of cultural practices which they regard as a stumbling block to progress. They may have to find a better approach of dealing with the many millions who believe in the spiritual causation of certain illness; or they

may simply continue to strive to dominate them into extinction, if they cannot tolerate them at all.

With South Africa's new legislation, traditional healers perceive the position proposed for them as being at the entry level to health care, confined to the role of primary healthcare workers whose sole task would be to supervise patients on behalf of the biomedical system. Their true status would be recognised in their own communities, but not by the biomedical system. When the suggestion was made to biomedical practitioners to try to work more collaboratively with traditional healers, they were equally uncomfortable with the idea (Eastman, 2011, p196).
Biomedical system saw traditional healers as "remnants of the distant past" (Eastman, *op. cit.*). Their understanding was that traditional healers were unskilled to make correct diagnoses and that their remedies would lack any scientific back-up. These suspicions between the two groups seemed inevitable, given their widely differing worldviews.

Mofokeng (2003, pp15-16) categorised African people who have absorbed Western culture through acculturation into two groups, that is, those having cultural blindness and those having cultural conflict. He assigned the epithet of cultural blindness particularly to those who were comfortable with their traditional practices before they came into contact with the ways of the West. The author explained that a culturally blind person behaves as if differences do not exist between cultures. He or she assumes that everyone ought blindly to follow the newly introduced culture and disregard their own; they would be pretending that their own has ceased to exist, although aware that it has not. He further explained that the experience of being acculturated into Western ways may also be marked by cultural conflict (Mofokeng, 2003, pp15-16). The person

may retain a strong awareness of his or her own culture, but have to abide by the newly-introduced culture for various reasons. The process, in other words, is marked with pretence and unreality. The person either pretends his home culture does not exist, or he hides his adherence to it and pretends to be at home with the dominant culture.

The biomedical health system has tried to absorb indigenous health systems into itself, but without real success. Based on the arguments presented above it could be easy for one to assume that the two systems will continue to coexist in an uneasy truce; or eventually the biomedical system will completely annihilate the traditional one. The West has tried to produce certain traditional remedies in a modernised way; examples would be '*muthi wenyoni*' (antacid) and '*amafutha enja yolwandle*' (genuine seal oil). Simpson (1989, p192) highlighted that:

> ... those practices most likely to be adopted are those which have an affinity with the cultural context into which they are being introduced and which have some practical value for the person expected to adopt them.

There have been examples where biomedical medicine has worked with people's perceptions, recognising their need for something which it was not previously provided. Simpson (1989, p192) notes that when some traditional people visit a hospital, they expect the doctors or nurses to offer them 'dramatic' medication, that is, 'symbolic' medication (Kleinman, 2010, pp88-89). Simpson gave the example of a nurse who was struggling to convince caregivers that what their babies needed to cure their dermatitis was to be washed regularly. The caregivers were expecting something more than that and their disappointment was noted by the nurse. She came up with a plan (Simpson, 1989, p192), to prepare bottles of sterile water coloured with green food

colouring. Every mother whose baby suffered from dermatitis was given this bottle and instructed to place 10 drops of it into the baby's bathwater. The method was a great success.

The same need for something strong or dramatic applies to South African traditional people. When it comes to *ukuhanjwa,* which is dramatic in it effects, they feel the need for something which shows evidence of its strength. Unfortunately this expectation is not met in biomedical centres. Mofokeng (2003, pp15-16) highlights what culture shock does to people. Culture shock is the feeling a person gets when suddenly made aware of cultural differences, leaving him or her feeling isolated and misunderstood. Rural people may well have experienced culture shock when they first realised that the sophisticated high technology biomedical health centre was unable to recognise *abantu* illnesses. They were expecting a kind of "super help", but their expectations were not met, resulting in a loss of trust in the biomedical system.

2.5.4. Possibilities for culturally congruent healthcare

A move by the World Health Organization (WHO) in 1977 to formally recognise traditional medicine and to encourage collaboration between biomedical and traditional healers brings hope to those who recognise the value of cultural healing in today's world as highlighted by Truter (2007, p60). The question to be asked is what form this collaboration should take so as to benefit both sides and not result in the dominant system swamping the weaker one.

Clark (2011, pp133-139) suggested a particular manner in which nurses should be trained in order to better understand the worldview of traditional cultures. The author suggested the prioritisation of social and cultural factors when designing and delivering care across multiple

contexts. This could be done through a constant evaluation of the dominant health care system, as to how it is relating to and taking cognisance of cultural beliefs and practices. The authors also encouraged the construction of socially- and empirically-derived cultural knowledge to guide nursing practices, so that nurses are able to attend to people in a way which is relevant to them. They propose, in effect, the transformation of health care systems to address social justice and health disparities.

The above suggestions, as they appear, are promising, but judging from the period since the recognition of traditional medicine in South Africa, they are unlikely to be put into effect. People still use their traditional medicines secretly, scared of being reprimanded by biomedical practitioners, and most of all, simply do not consider the biomedical health system adequate for dealing with *abantu* or spiritually-caused illnesses.

In addition to the three models already discussed for the future of traditional medicine, Sobiecki (2008, pp333-351) and Krige (n.d.) advocated for an inclusive system, whereby both systems exist completely independently of each other although not at the same level of acceptance as biomedicine would be dominating. Although Krige (n.d.) accepts the existence of traditional healing methods as they currently are alongside biomedicine, she would prefer traditional healing methods to follow a more scientific approach with regard to dosage measurements. These authors also consider an integrated system according to which both systems merge into a new system that combines the best of both, according to Western values. With the exclusion of the exclusive model, which keeps traditional medicine out in the cold, the two models

accommodate traditional healing methods but ensure that Western values and the hegemonic tendency of biomedicine is maintained.

There is certainly greater acceptance nowadays than there was fifty years ago of traditional medicine. Both systems are understood to have "valuable contributions to offer in the quest for health" (Krige, n.d., p9). Yet it cannot be denied that the Western system would prefer traditional healing to be conducted almost in the same way as that of the biomedical health system. Hence the establishment of structures like the Interim Traditional Health Practitioners' Council and the Association of Traditional Healers. The biomedical community has not yet found any reason to tolerate or even accommodate traditional beliefs in viable public healthcare centres (Eastman, 2011, p189). Possibly Levine (2012, p66) is right when she says that traditional medicine has always been viewed as dangerous and irrational.

Browner *et al.* (1988, p681) in Quinlan (2011, p381) proposed a way in which the emic aspect of ethnomedicine could be combined with the etic aspects of biomedicine. The author proposes the identification of health problem and how they could be conceivably healed according to locals, objective assessment of the remedy's ability to produce the emically desired effect, and identification of areas of convergence and divergence between the emic and the etic assessments.

Throughout this literature review it has been shown that the two healing methods have divergences (healing approaches and instruments used for healing), and convergences (the intention to heal the sick person). It is clear that one healing method has continued to evolve and spread all over the world at a pace which makes those who subscribe to traditional healing

methods feel overwhelmed. The biomedical healing method carries with it – as to all healing methods – the assumptions of the culture from which it springs. Its dominance is perceived not only as a dominance of a way of healing, but a dominance of culture. This sense of being faced with a dominant culture which has no place in it for the beliefs of a traditionally-minded community causes a reaction. Holding on to traditional health practices is seen as vital not only for healing, but for maintaining culture and identity. Thus the practices of traditional systems of healing continue to flourish the world over.

2.6. Summary of the chapter

In this chapter a discussion has been presented on various issues pertaining to illness and health, making use of empirical literature, which has made a contribution towards providing a hypothesis for further research. The literature captures empirical reports from international, continental, national and provincial research in the field of traditional health systems, and has revealed the influence of culture in defining illness and health, and the relationship that exists between the biomedical health system and traditional health systems.

Different worldviews are understood to be inextricably linked with culture, and result in different meanings being attached to illnesses, and different methods of healing being practised. The indigenous worldview involves an holistic health paradigm (Mofokeng, 2003, p13), with illness interpreted as the manifestation of a disturbance in equilibrium. This equilibrium is vast in scope, encompassing the internal state of the individual as well as his relationship with family, community, ancestors and God. It is essentially spiritual in nature, hence the designation of various illnesses as “metaphysical” or “theological” by the biomedical community. The Western

worldview is rationalistic, and its health system is therefore empirically-based and naturalistic. The two systems have been shown through the research and writings of various authors to diverge strongly, though not without points of commonality.

It has been explained that traditional healing methods have their shortcomings, but the biomedical health system has its weaknesses too. Hence people adopt a pluralistic approach, using elements of each system, depending on the illness in question. There is a strong element of secrecy in the practice of traditional healing methods, partly as a result of the pressure brought to bear by the dominant biomedical system.

The issue of culturally congruent health care has been raised by a number of authors seeking a way for the best of two systems to be combined. How this might be accomplished has yet to be discovered.

In all the literature, the dominance of the Western biomedical system has been remarked upon, as has the intriguing resilience of traditional health care. The assumption by the biomedical community that all systems will eventually become subsumed into the biomedical health system, as they evolve and catch up with the Western worldview, is challenged on many fronts. One is the theory of cultural modernity, which states that all cultures evolve and become modern in their own unique way. “Modern” in the cultural context does not necessarily mean “Western”.

Despite the strong areas of divergence between the rationalistic Western and the traditional worldviews, debates and plans continue to be made on the possibilities for a culturally congruent

healthcare system. Whether or not this is possible, it is clear that greater understanding between the two worldviews may benefit the practice of medicine. It is hoped that the findings of this study might bring to light a particular condition amongst a particular people – *ukuhanjwa*, amongst the Southern *Nguni* people of OR Tambo District Municipality in the Eastern Cape – and challenge those who continue to remain sceptical of the existence of this and other *abantu* illnesses.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1. Overview

The empirical phase of the study involved choosing the research area, the targeted population and the sample size relevant to the needs of the study, seeking permission from local authorities to conduct research, and gaining entry into the field using contact persons or other means to gain trust from participants and community members. The researcher's fluency in the local language was a definite advantage.

The researcher decided to collect data personally without the help of other fieldworkers for, as Okely (2012, p23) highlights, a report cannot be fully comprehended at the write-up stage by anyone other than the fieldworker. The researcher wanted to have personal experience and not reported experiences from which to draw. The study had to be delimited in terms of the research area and the scope of research for feasibility purposes. The study had limitations and the researcher had to indicate how she counteracted those limitations for better results.

In addition to limitations, there were also challenges which had to be faced by the researcher during the time of the write-up of the dissertation. The researcher suddenly lost her mother a week after a severe stroke, during which period her mother could neither move nor speak. The support of her supervisor, relatives, friends and colleagues at work made it possible for her to regain her strength and resume her work. The momentum was disrupted by occasional load shedding of electricity in the whole of South Africa. In the area where the researcher was residing at the time of the write-up of the dissertation, blackouts were especially frequent, long

lasting and unannounced, sometimes lasting for three to four days. She found herself moving from one place to another in search of electricity, creating some sense of helplessness since it was a situation she could do little about. All these events delayed progress. The researcher was not, however, discouraged by these events but instead, her morale was boosted by an invitation which came from a group of Canadian academic writers requesting her contribution to a book on traditional healing, with a chapter entitled 'Managing witchcraft: Methods used in healing ukuhanjwa in South Africa'. Although one would assume that writing a book chapter for publication was another form of delay to the dissertation, recognition of the researcher's PhD study by international academics was a refreshing breakthrough for her.

3.2. Research design and methodology

The research design included a review of all the research methods available, with a careful consideration of the advantages and disadvantages of each. Where disadvantages of the chosen method became apparent, ways had to be found to counteract those disadvantages so as to minimise or avoid errors and maximise the study's reliability and validity. Bless, Higson-Smith and Sithole (2013, p131) have highlighted the purpose of research design as a way of ensuring high internal validity. Designing a methodology is a step-by-step process and involves key activities embarked on to implement a chosen research method (Cassim, 2014, p81). Thus methodology begins with selecting the targeted population, followed by sampling and the design of research instruments for data collection and analysis. A detailed description of research design and methodology followed has been provided below.

3.2.1 Research design

Ethnographic and qualitative methods of research were used for the study. The qualitative research method was used in order to compare the various experiences of community members in all the local municipalities of OR Tambo District Municipality with regard to the chosen illness - *ukuhanjwa*. The qualitative research method assisted in determining whether different groups of people have had similar responses to the illness in question or had responded differently. Most of all, it was important to know whether the perceived source of healing power was the same in all geographic areas, and to what extent this perception played a role in the continued use of the healing methods chosen. All of this became possible to achieve because qualitative research, according to Barker (2003, pp24-30), concentrates on the interpretations and meanings generated by a cultural group of people as would be favoured by cultural studies. The qualitative research method was conducted across all the five local municipalities (Ingquza Hill (IHLM), Port St Johns (PSJLM), Nyandeni (NLM), Mhlontlo (MLM), and King Sabatha Dalindyebo (KSDLM)) of OR Tambo District Municipality (ORTDM).

Taylor (2001, pp1-9) recommends the ethnographic method of research accompanied by participant observation, especially with regard to ethnomedicine, in order to study the underlying cognition surrounding a phenomenon. The ethnographic research method is meant to assist the researcher in validating the findings, by making it possible to say, "I was there" when things happened, as the "baseline of anthropological authority" (Fontein, 2014, p56). It involves the researcher's presence amongst the people being researched for extended period of time, so as to yield the opportunity to witness things happening. For this study, the ethnographic research method was only employed at KwaThuwa, Nyuleni, Nomadolo and Detyana locations up to

Canzibe Hospital in the Nyandeni Local Municipality. The ethnographic research method was conducted in order to cross-check the reliability and validity of the qualitative research findings.

3.2.2. Methodology

3.2.2.1. Targeted population

The population for the study included parents whose children have experienced *ukuhanjwa*, traditional healers who have dealt with the illness, as well as adults who may have personally experienced the illness. At first the proposal was to focus on the illness as a childhood experience, but as interviews progressed, some mothers indicated that they too had experienced the illness, although in a mild way. It was clear that it was mostly a childhood illness, affecting both girl and boy children, but not exclusively, since during interviews it was also discovered that adults are also vulnerable to the illness. Despite the fact that fathers traditionally play a small role in the day-to-day supervision of children, fathers were included in the study, to see whether the interpretation of the illness varied according to gender. Some biomedical health workers - nurses and physicians - also participated in the research, although under the umbrella of community members. Only two physicians were available for interviews as community members in the KSDLM. Children could not form part of the population for reasons mentioned under ethical considerations.

3.2.2.2. Sampling techniques

Mark and Lyons (2010, pp1756-1764) used the snowballing technique for their study, beginning with friends and associates and gathering more participants by word of mouth. At first, it was

proposed that the same technique would be used to identify mothers whose children have or have had *ukuhanjwa* in the last two years. But in the field there was a change of plan since some elderly women were also forthcoming about their children's experiences years ago with the illness. Thus all ages were considered, irrespective of how recently the illness was experienced. This also assisted in verifying consistency or otherwise in the healing methods and in the understanding of the illness extending back over a time period of about forty years.

The stratification of participants thus became necessary so as to differentiate between the responses of males and females, young an old. It was first proposed to categorise ages in the following manner: 20-29, 30-39, 40-59, 60 and above. But in the end a decision was made to group those from 20 and 39 in one category, making sure however that participants in this category included one from each of the combined age groups. The same procedure was followed for the ages 40 to 59 and 60 and above. This purposive stratification was done in such a way that there would be two older mothers, one aged 60 or above and one aged between 40-59, and two younger mothers, one aged 30 to 39 and the other aged 20-29. The same applied for the two older fathers and the two younger fathers. All the categories included both illiterate and literate people.

Sampling included two traditional healers, one male and one female, from each of the five local municipalities, bringing the total number of participants to fifty – about ten per municipality. Participants were selected from remote rural areas, peri-urban areas and urban areas so as to test the statement by Fabrega (1997) in Baer (2011, p412,) that there are healing methods for the elite and less prestigious healing methods for "subordinate segments of society". Another reason for

the inclusion of all three types of locations was to test the truth or falsity of the assertion by Levine (2012, p66) that some anthropologists believe that traditional people relinquish traditional healing for *abantu* illnesses once they become urbanised. Samples from all three areas also helped to establish whether there were differences with regard to the perceived source of healing power between the three groups. Lastly, the three groups were included so as to establish variations in attitudes towards biomedical healing as an alternative or supplementary form of healing.

3.2.2.3. Research instruments

For in-depth interviews, an interview schedule for qualitative research was used together with field notes. The interview schedule was mostly used for qualitative research across the five local municipalities. Close observation of participants was necessary, in order to establish what community members experience when collecting and preparing plants for healing; how far they have to walk, what times of day were preferred, which plants were selected and why. Since the researcher stayed in the homes of some participants, she was able to observe these aspects, as well as various activities around the home, all enabling ethnographic research.

In addition, four focus groups were engaged with. One was a group of pensioners, both males and females, in Ingquza Hill Local Municipality. They had banded together to support one another in living a healthy lifestyle, which included playing soccer (both males and females), the production of traditional clothes for selling, and the cultivation of a large vegetable garden. Each time the group met, they would prepare a meal of healthy foods, including the vegetables that they had grown. They were very enthusiastic about their group and indicated that the soccer kept

them fit and ready for matches against similar teams of older players from other villagers. This group was composed of about twelve elderly people aged 60 and above. Not all the group members were present on the day of the interview. This group was interviewed because they were old and likely to have the indigenous knowledge required for the study. The fact that the group was composed of both males and females helped to establish the knowledge distribution amongst males and females regarding the illness as well as the role played by males in managing the illness. It is well known that traditionally it is the duty of females to take care of children around the clock.

Another focus group was a group of young and middle-aged women who called themselves the *Philisa* (Heal) Project, at Nyandeni Local Municipality (NLM). At the time of the interview there were eleven members of this group. Their responsibility was to monitor the child-headed homes so as to ensure child welfare and order. This group was organised by the daughter of the elderly person who was hosting the researcher. The daughter had fouded and continued to take an active role in the group as a volunteer. The group was considered for interviews because they were of the age group to have experienced acculturation; they were likely to be able to reflect on whether acculturation had played any role in determining the healing methods and responses of acculturated people to *ukuhanjwa*. This same group would help to explain the extent of enculturation that had taken place regarding identification, healing and prevention of the illness in question.

The third focus group was composed of ten nurses, although they were interviewed as community members and not specifically as representatives of the biomedical health system.

This group was interviewed whilst the researcher was at Nyandeni Local Municipality. Their responses yielded a rich diversity of data, as they were able to address the issue of traditional healing from the perspective of those who were both community members sympathetic to traditional healing, as well as professionals, educated and knowledgeable on the biomedical health system. Their ages ranged from 25 - 45. The nurses gave two case studies, one of which was intended to prove the existence of *ukuhanjwa* as a valid illness, and detailed the preferred healing method from the Southern *Nguni* perspective.

The fourth and the last focus group was interviewed at King Sabatha Dalindyebo Local Municipality (KSDLM) in Mthatha. The group was composed of five women ranging from ages 30-35. They were a group of well-educated, working women. They were convinced that *ukuhanjwa* exists, basing their evidence on the case of their friend's child.

Several case studies were conducted within the same study which demonstrated the existence of witchcraft as well as *ukuhanjwa*. The case studies were particularly convincing, leaving the researcher almost convinced of the reality and power of witchcraft as well as the existence of *ukuhanjwa*. Case studies helped in gathering knowledge using in-depth ethnographic examples which were provided by participants on what they believed to be real experiences on *ukuhanjwa* and witchcraft activities.

Field notes were also written, where observations and conversations were recorded for easy recall at the analysis and interpretation stage

3.3. Empirical phase

This section gives a description of the research area and a rationale as to why this research area was selected. It also presents how data was collected and discusses challenges which were confronted by the researcher, as well as methods employed to overcome these challenges. An explanation is also given on strategies used to gain entry into the research area, and to establish the trust of participants. These aspects are particularly important, as insensitivity to them can result in the unwillingness of participants to give more than superficial information and can jeopardise a research project.

3.3.1. Description of the research area

The study was conducted in the OR Tambo District Municipality of the Eastern Cape in South Africa. OR Tambo District Municipality comprises a mixture of people commonly known as *amaXhosa, amaMpondomise, amaMpondo* and others who are sub-groups of the Southern *Nguni* tribe. It was difficult to specifically identify which of these sub-groups predominated, since people relocate frequently, resulting in mixed settlements of all of these groups in the research area. This is one of the reasons that reference is made in this study to local municipalities instead of sub-cultural groups of the Southern *Nguni;* the area is home to all of these sub-groups. The intention was in any case to conduct research amongst a diverse representative of the Southern *Nguni* people of the area.

The District was previously composed of seven local municipalities, that is, King Sabatha Dalindyebo (KSD), Nyandeni, Ingquza Hill, Mbizana, Mhlontlo, Ntabankulu and Port St Johns. Later these were reduced to five, omitting Mbizana and Ntabankulu (OR Tambo District

Municipality, 2013, p1). Three maps have been attached as appendices for locating OR Tambo District Municipality. The first map is that of South Africa showing the location of the Eastern Cape, and the second is of the Eastern Cape showing the location of the OR Tambo District Municipality and the five local municipalities as mentioned. The last map shows the five local municipalities of the OR Tambo District Municipality.

The reason for choosing this area was that the researcher had previously conducted research in one of the local municipalities of the District and had come across *ukuhanjwa*, an illness which at the time was outside the scope of the study. Familiarity with the language of the area was also a motivation, as people were more likely to speak freely with someone who knew their language. Having prior knowledge that there were people in this area who were familiar with *ukuhanjwa* was another motivation, since the intention of the study was to understand this illness and the thinking surrounding it of people who had actually experienced it. A particular interest was whether adherence to traditional interpretations and healing methods was as a result of the perceived source of healing power, and what the perceived source of healing power was.

Economically and socially, the area comprised three types of household – urban, peri-urban and rural. Conditions in these areas varied. Those in the remote rural areas had enough food to eat, but only just. Hosts lacked confidence in offering their food to an outsider, because it was generally thought fit only for family members who would understand their financial constraints. They always made effort to provide, although the outsider would immediately assess the situation as seriously lacking. The National Research Foundation funds came in handy in such situations, enabling the researcher to make a contribution towards supplies. Households in the

peri-urban areas fared better as most homes in these areas had at least one or two members earning a wage, no matter how little. Those in the urban areas could be categorised as working or middle class homes, with very few wealthy homes.

The people in the research areas visited appeared to be socially stable. Those with responsibilities towards their families appeared to take their responsibilities seriously, and would maintain their homes and economic obligations with firmness and dignity. The host family for ethnographic research, for example, although lacking a responsible male, had an unmarried daughter working as a nurse, who supported the elderly mother and her grandchildren without fail every month. In addition, the mother received a state pension and grants for all of her grandchildren, making this one of the better-off families in rural areas. Despite these means of income, the amount received was not enough to sustain them well, and they lived from month-end to month-end. Other families in rural areas were far less well off, and depended on pensions and child care grants to survive. None of the homesteads maintained their traditional mealie fields, and cultivated only small plots of cabbage close to the house. This abandonment of mealie fields could be one of the reasons that food shortages continue to prevail in these areas. Despite these circumstances, people did not go hungry, as the rural practice of caring for one's neighbour prevailed. Families would support one another with the bare necessities, meaning that nobody went without food for a day.

3.3.2. Gaining entry into the field and gaining the trust of participants

After writing the proposal, the researcher needed to gain permission from various bodies and individuals in order to conduct research in the area. Fortunately, at the time permission was

sought, the OR Tambo DM had a central office in Mthatha where all the chiefs of the various local municipalities under ORTDM met to discuss issues of relevance for the District. Written consent was needed from one of these chiefs. In addition to this, verbal consent would be required from each of the chiefs when the researcher arrived in his area. This was necessary for practical reasons. Should anything happen to the researcher while in an area under a chief's jurisdiction, he could not be held responsible if his permission had not been sought; whereas his verbal consent to the researcher's presence extended a measure of protection over the researcher. Secondly, permission also had to be granted by the Municipal Manager of ORTDM. Both the chief in Mthatha and the Municipal Manager granted permission verbally, but getting this in writing turned out to be more of a challenge. Amongst the chiefs there was some dispute over which chief had authority to sign. Ultimately, the researcher had to convince the chiefs to allow the chief who had already granted verbal permission to sign the written permission, and to sort out the issue of whose responsibility it was later. The Municipal Manager was unable to give written permission for a considerable time due to constant engagements, but eventually both these letters were obtained and research could proceed. The two letters of permission have been attached as appendices.

Friends and local people were used as contacts to assist in recruiting participants. In cases where a contact already existed from previous visits to the area, this person was approached and willingly agreed to help, as rapport had been established in the past. The immediate help needed was an introduction to the local chief for permission to conduct research in the area. This was the situation in the Nyandeni, and Ingquza Hill Local Municipalities. In Nyandeni Local Municipality, the host person was Nosebenzile*, an elderly woman aged 71 at kwaThuwa

location, which is close to Canzibe Hospital and Nomadolo Junior Secondary School. She cared for many of her grandchildren from her nine children, with some already at high school and therefore staying on their own in rented flats near their schools. She was exceedingly happy to host the researcher, despite her poverty. One of her daughters lived with her, although away during the day working as a volunteer at the Philisa Project. As a person known and much respected in her community, she was able to assist the researcher in gaining entry into the village. Her daughter, too, made herself available to accompany the researcher to key places such as the offices of Philisa project, the Canzibe Hospital and Detyana location. All members of Philisa project assisted in different ways by providing information on *ukuhanjwa*. The leader of this project, Siziwe* also helped by taking the researcher to the place where medicinal plants were collected as they insisted that they could not use any traditional medicine growing inside the premises of their homes. Their belief was that those traditional medicinal plants have been weakened by familiars which have tramped over them when they have come to attack the victim. Members of Philisa project offered to assist with any other project the researcher might conduct in the future, an indication of the level of trust they developed towards the researcher.

At Ingquza Hill Local Municipality the host person was Nokuzola*, a woman of 59, residing at kwaGqwarhu in Xhorhana location. She also had a large number of children, two of them working, and a husband, Zakhele*, aged 90. The wide age gap was indicative of cultural practices which are acceptable in rural African communities. Zakhele himself was fit and active enough to walk long distances to visit neighbours, as well as take taxis on his own. Nokuzola* and Zakhele* relied on Zakhele's pension. Their two employed children, a son and daughter, earned very little as a security guard for a local spaza shop and a domestic worker respectively.

Nokuzola* asked her husband to accompany the researcher to the local chief to request his permission for conducting research in the area. The chief referred the researcher to the headman, saying that the headmen had complained in the past that all community matters should start with them so that, where necessary, they could refer things to the chief, and not vice versa. Thus protocols had to be observed. The researcher was however received with warmth and trust in all the homes she visited in this area, probably as a result of being accompanied by this respectable old man of 90.

In cases where there were no ready contacts, the researcher had to establish them on her own. At Qokolweni location in King Sabatha Dalindyebo (KSD) Local Municipality, there was no-one to introduce her to the authorities or to help identify participants for interviews. Driving along the road, the researcher decided to give a lift to a middle-aged mother, Zodwa*. The researcher quickly introduced herself and the purpose of her visit in the area, and took Zodwa* to her home, which was not far from the pick-up point. Zodwa* seemed honoured to have been helped in this way, and a warm rapport was easily established. She explained to the researcher how she had come to live in this home; how her marriage had broken up and how, after staying some time at her paternal home, she had been forced to leave and build a home of her own because of conflicts with her sister. She had, in fact, left in such a hurry that the home she was now living in was not quite complete. She asked her eldest daughter, Nathi*, to be the researcher's contact person, introducing her to the relevant participants, and Nathi* agreed.

At her home Zodwa* was caring for two grandchildren, a boy and a girl, from her daughter who had been born before she married, and her own three children from her marriage, a girl and two boys. On the day of the researcher's arrival the family had two visitors, a husband and wife, who gladly participated as interviewees. The husband was in fact the builder who was trying to complete the half-finished home.

Nathi* referred the researcher to various people including certain of her relatives, as she knew that they had experienced *ukuhanjwa*. One of these was her grandfather who was a traditional healer and successfully healed cases of mild and severe *ukuhanjwa*. One of the participants Nathi* took the researcher to see was an elderly woman whose own grandmother had admitted to being a witch.

The same procedure was followed in the Port St Johns Local Municipality. As she drove towards Port St Johns, the researcher had no idea where exactly she was heading. *En route*, close to Port St Johns, in an area known as Ntsimbini, the researcher gave a lift to a young lady on the road. Whilst conversing with the young lady, the researcher introduced herself and mentioned the purpose of the visit. Once they reached the young lady's home, the researcher was introduced to her mother, Nokholo*, aged 49, with her young granddaughter. The mother offered to become the researcher's contact person, and became a participant herself as she had had personal experience of *ukuhanjwa* in herself as an adult, as well as in her eldest child. Though she was a committed Christian, she acknowledged the existence of the illness and shared a common understanding of it with many traditional people.

Nokholo*appeared to be coping financially as she had a small business transporting school children. Although she had agreed to be the contact person, she realised that with her busy schedule, she would not have the time, and asked her neighbour, Nozamile* aged 52, to continue from where she had left off. Nozamile turned out to be an excellent contact person and able to connect the researcher with many informative people. Her husband also became one of the participants and had a deep knowledge about *ukuhanjwa*. The level of trust established with this family even led to their allowing the researcher to find a job as a domestic worker for one of their granddaughters. Finding contacts so easily in both of these areas – Qokolweni and Port St Johns - made life in the field much easier than had been anticipated.

At Mhlontlo Local Municipality, the researcher had to pick a homestead randomly at a place called Lotana location. In the homestead, she found a husband and wife living with their children. After the researcher introduced herself as a researcher (*imfuna-lwazi*), detailing the needs she had in order to do her research in the area, their first question was whether there would be any financial reward for their help. The wife, Nokwakha*, expressed her discomfort, saying that most researchers worked only for their own personal gain. The researcher then explained that the intention of the research was to contribute to a written record on indigenous knowledge, so that it would be preserved for future generations and not be lost forever. She explained that there was a great need to preserve the old knowledge, which was in danger of being lost, so that the younger generation would benefit from the wisdom of previous generations. After hearing the explanation and intention of the study, they began to relax and trust the researcher, although Nokwakha* referred to her doubts quite frequently. In the end, however, she became the most dedicated contact person, even calling the resercher months after the study ended to inform her

about the death of the local traditional healer. This was an indication of the level of trust and attachment which was established during the research period.

Throughout this period in the field, it became obvious to this researcher that the way one interacts with community members has a huge influence on the quality of the data collected. Without this level of trust, the intimate knowledge, and the breadth and depth of the explanations for the illness, would not have been possible. At the same time, the greater the trust between researcher and participants, the greater the sense of attachment from one side to the other may be. Where a participant develops an attachment, there is the danger that the researcher may forget a sense of perspective and objectivity. There is a need to reciprocate friendship in an acceptable manner but caution must be exercised not to exceed the limit. Some researchers allow a sense of attachment to the extent that they will follow up field studies with personal visits such as attending ceremonies and funeral services when invited. This sort of follow-up depends on the researcher.

For this study, the researcher decided to minimise involvement in the wider OR Tambo District Municipality, and focus the more personal involvement in one area, kwaThuwa in Nyandeni Local Municipality. This was where the ethnographic study was conducted. For this reason, she attended funeral services and other ceremonies as a gesture of goodwill towards the host family. It was here that she spent the longest period of time, establishing strong ties, which helped in the gathering of ethnographic data. In other areas, when invited to attend some of these ceremonies, the researcher would turn down the invitation in a very polite manner, so that no offense would be taken.

It is also extremely important to respect and honour protocols when entering an area. After meeting a contact person, the next step was always to pay a visit to the local chief and request his permission to conduct research in the area. In this researcher's experience, the chiefs were friendly and expressed delight that people still had such high regard for traditional practices that they observed the protocol of visiting them first. In one chief's home, the friendliness was not as marked; indeed, the chief seemed uncomfortable to have the researcher in his home, although he willingly gave his permission for the research and extended his protection over the researcher for the duration of her stay. But he seemed eager to be rid of the researcher and the elderly man accompanying her, referring them to the headman. On the way back, the elderly man explained his suspicion that the chief was unhappy because he could not get the opportunity to ask the researcher to be his girlfriend, as he was well known for being fond of women. In that particular location, it is a common practice for chiefs to have as many girlfriends as they wish. Fortunately protocols had been observed and no further attachments were made since there was no further need to go back to the chief's place after meeting the headman.

The fact of most participants' poverty had always to be born in mind, especially when staying with a host family. It was disturbing to find that in the homestead where the most time was spent during the research period, economic conditions were so bad that there was a need to contribute to substantially to the family's needs. This contribution was in the form of groceries. Money would have been less helpful, as prices were cheaper in the city of Mthatha than in the village.

Most of the homes where the researcher stayed were in a similar position, except for those in *Mhlontlo*, KSD and Port St Johns Local Municipalities. These three contacts were self-employed, two of them selling small items to the schools, and the third engaged with a transport contract, taking pupils to and from schools. In all homesteads, there was minimal agricultural activity with the traditional mealie fields having been abandoned and only small scale cultivation taking place in small plots near the homes. In all homes where the researcher stayed, varying amounts of groceries were contributed. In the case of qualitative research, two or three days would be spent at the local municipality but for ethnography, an extended period of time was spent for in-depth information followed by occasional visits to close gaps discovered during analysis and interpretation of data.

3.3.3. Personal experience

For this study, the researcher relied to some extent on experience and knowledge gathered on previous trips, when she was gathering information on other, related topics. Previous experiences with community norms and practices were, of course, not necessarily relevant; nevertheless the researcher decided to apply these cautiously across all areas. On previous trips, the researcher had been advised to dress as if she were a married woman, so as to avoid abduction. For this reason the researcher wore long skirts throughout the research period in all areas, whether remote rural, peri-urban or urban areas. This was particularly important during the in-depth ethnographic research. It minimised any possible misconceptions which might have occurred, based on different cultural practices and beliefs.

In all homes, the impression the researcher received was that people expected the researcher to eat together with them, no matter how little the food they had and no matter what it consisted of. They would not have been happy allowing the researcher to occupy her own room and cook separately. To them it felt more human, more in line with *ubuntu,* to share their space and food with the researcher no matter how little they had. Fortunately, there were the National Research Foundation (NRF) funds to assist the researcher in economic conditions of that nature.

The attention, trust and respect that the researcher experienced in these homes had nothing to do with the researcher's credentials or status, but were because of the manner in which she interacted with people. Respect, humility and gratitude were reciprocated with kindness, warmth and trust. The researcher's thorough explanation of the rationale for her research also added value to her interactions with community members. They were able to see her presence there as of benefit to the community and directed ultimately towards community development rather than just personal gain. The majority of participants never asked for financial compensation for their participation, except for the one participant from Lotana, Mhlontlo Local Municipality, as already mentioned. She stated that researchers get financial rewards for their work, and questioned why those who helped should not share in those rewards. Eventually, however, she agreed to help without seeking reward, and became a trusted and helpful contact person.

Interestingly, a similar example of reticence to help came from a diviner, who held to her position that her information was not to be shared. She refused to reveal which medicinal plants she used to heal *ukuhanjwa* or *urheqo* stating that she had refused to reveal these plants even to her own mother, who had once brought a white man to her who offered to purchase the plants for

R5000.00. She maintained that she could not even reveal the name of the plant nor allow the researcher to view it. Her fears were that another person could sell the plant for his or her own profit and by doing so, take away all her clients. Unfortunately a few days after the researcher left her area, she had to be taken to hospital because of ill health and died soon afterwards. This was the second diviner to die after having been interviewed for the study. These deaths confirmed to the researcher the necessity of her research, as diviners and other elderly people who had the specialised knowledge of traditional healing were dying without leaving any records.

3.3.4. Delimitations of the study and research area

At the planning stage of the study the intention was to focus only on *ukuhanjwa* in infants and not work with *ukuhanjwa* in adults. The reason was that it had appeared, from previous knowledge of the topic, that the illness was a childhood illness. The intention was to speak to the parents of children who had experienced it rather than the children themselves, as children are a vulnerable group and in any case would need parental consent. It was viewed as better research practice and more sensitive to work instead with parents and traditional healers. The plan changed when research began, as some of the mothers said that they too had experienced *ukuhanjwa* as adults. With them the illness was confined to the mild stage and never became severe, as is so frequently the case with children. In total, three mothers participated as adult victims of *ukuhanjwa*. It remained a predominantly childhood illness and was treated as such, but the scope of the research was broadened so as to include adults.

Geographically it was practical to limit the study to the Southern *Nguni* of the OR Tambo District Municipality instead of the whole of the Eastern Cape. Qualitative research methods were employed for all five of the ORT municipalities, using the interview guide as the instrument for interviews. Ethnographic research methods were used in one ward of *Nyandeni* Local Municipality. Even with qualitative research method, research was limited to ten participants per local municipality, in view of the resources and time allocations given to this research.

3.3.5. Data collection

The collection and analysis of data was done almost concurrently until the write-up stage, which helped the researcher as she was able to fill in gaps in data as she considered and interpreted her findings. Data was collected from specified age group categories, which helped to determine whether knowledge and interpretation of the illness varied by age group. In effect, the age group categories helped to determine whether knowledge had been transferred from one generation to another, or whether acculturation had clouded the interest of the youth in pursuing indigenous knowledge.

Field research started with the use of the interview schedule for qualitative interviews from all five local municipalities of ORTDM, as explained under sampling and research instruments. Qualitative interviews were followed by the ethnographic research method in one geographic location, where no time frame was observed, since participant observation had to be continuous until there was saturation of data and understanding. Field notes were of course written, where observations and informal conversations with participants were recorded.

The literature review assisted a great deal in the analysis, interpretation and presentation of data as it helped to place the findings in a context, and gave much practical help. For example, specialised documents such as the Constitution of the Republic of South Africa, of 1996, were consulted with regard to children's rights. The 'Children's Bill of Rights 28(1) (d), p13.' impressed upon the researcher certain lines which are not to be crossed when working with children. It helped to make the decision not to interview children directly but rather to consult their parents, and also, not to photograph children. The participants themselves were informative and had no objection to revealing names of medicinal plants or of the so called Dutch medicines which have been indigenized. The experience in the field brought home very clearly that the manner in which people conceptualize things is shaped by their worldview and the way they have been socialised.

The ethnographic research method helps in gaining insight into people's belief systems (Winkler, 2010, pp162-170) for better data analysis and interpretation of data. Time spent in the field gave exactly that insight, and helped to explain why people from a different culture would have such difficulty in understanding or influencing the worldviews of traditional people. Ethnographic research also helped in rendering full descriptions of the illness in question and thus helped with data analysis, as is explained by Berreman *et al*. (1971, p340).

The physical space for interview was also considered (Naidu and Ojong, 2010, pp96-112). A place where interviewees would feel comfortble and relaxed was essential, and here the fact that the research methods were qualitative and ethnographic made a difference, for interviews in

people' own homes was of course the norm. Intimacy and a high level of diclosure was common during interviews as a result, greatly enhancing the findings. In fact, friendships ended up being extended to the point where interviewees invited the researcher to attend funerals and other ceremonies long after collection of data was complete; in some cases, such invitations had to be politely delined, as a way of maintaining the balance between work and socialising.

3.3.6. Limitations of the study

The study did have limitations. One of the greatest limitations was the nature of the illness itself, which made it almost impossible to view a person suffering from the illness. The researcher had hoped to observe a person suffering from *ukujanjwa* and obtained the agreement of participants that should it occur, they would do their best to enable her to view the victim. Participants made no promises, stressing that familiars attacked without warning and that when they did, it was imperative to act swiftly. They would not have been able to delay treatment for the sake of a researcher. The closest the researcher could come to the illness was the baby girl who slept for almost half of the day, whose mother gave her traditional medicine to wake her.

Thus reliance had to be on the descriptions and explanations of the illness given by parents and traditional healers, as observation and taking of photographs was not possible. The researcher had to have the ability to present the information exactly as presented by participants, without distortion. Hence it was imperative to be thorough with the interview guide responses and field notes.

Illiteracy was a factor which slightly slowed the process of recording responses. The interview schedule was composed in English, with the researcher having to translate and write for participants. Though slow, it ensured a very thorough response, as the interviewer had to keep checking with participants that what had been written down was exactly what they meant, thus giving them an opportunity to clarify and expand on their responses. Fortunately, language, which could have been the biggest hurdle of all, was not a limitation as the researcher spoke the language of the participants. Responses were written in the participants' language instead of English in the interview schedule for maximum collection of data and to avoid distortion of the information and delay which could result in omission of important information. Translation was done at a later stage during the write-up of the dissertation.

The length of time required to collect good quality data may be seen as a limit or drawback of the study. This was particularly so because the researcher had taken the decision to do all of the interviews herself and not employ assistants. Although the use of assistants saves time, it has disadvantages for both qualitative and ethnographic research since individualse are bound to have differences when it comes to analysis and interpretation. What might be important to observe and note for one person might not bear equal importance for another. Distortions of the total picture are thus likely to occur. Ethnographic research cannot be done overnight. It is necessary to be patient and to allow people to continue undisturbed with their daily activities. Thus the researcher needs to become temporarily part of the family and engage in daily activities of the homestead, which is exactly what was done by the researcher. The obvious limitation of working alone when doing ethnographic research is the fact that the researcher cannot be all over the research area at all times to observe events everywhere - hence the possibility always exists

that the researcher may have missed seeing a victim of the illness by simply being elsewhere engaged.

3.4. Trustworthiness of the data

For the qualitative interviews, data was collected using an interview schedule in the form of a questionnaire for each participant. These were filled in slowly, with the researcher writing down the responses, after translation to the participants and translation of their responses back into English. Though the interviewer wrote down the responses and translation was involved, it added to rather than detracted from the trustworthiness of the data for, as explained earlier, it gave participants a chance to correct and amplify their answers. Field notes were written and kept for data confirmation. In these field notes, observations as well as conversations with participants were recorded in as much detail as possible. These will be kept in case the need arises for confirmation of data.

Conducting research of this nature can lead to questionable results in terms of the authenticity of the written record. In addition, getting people to talk on topics that are not normally discussed but rather just practised creates an unnatural scenario, with people having to explain things that they may be unaccustomed to explaining. Thus the possibility exists that their explanations are not an in-depth reflection of their true feelings, thoughts and behaviours. However, these possible drawbacks have been overcome through a sensitive and patient approach, where the researcher cross referenced participants' responses with one another, and gently probed for more information and clarity where necessary. In addition the raw data is stored in a safe place for a

considerable period of time (a maximum of five years as prescribed by the university) so that it may be cross-checked with other data should the need arise.

The research process itself guarantees a level of credibility as it involves focusing, discussing and thinking by interviewees on a very specific and defined subject. The probing done by the researcher further refined and added value to the participants' responses. The researcher would not have felt happy about entrusting such probing to hired assistants, as they may have lacked the patience and perspicacity for such a task. This understanding is backed up by Okely (2012, p23) as indicated in the overview section above.

The presentation of data may also have an impact on the credibility of the work. An incorrect interpretation of data could arise where the researcher disregards the worldviews and the voice of the participants, imposing his or own interpretation onto to their words. Hence the report has included as many direct quotations of the participants' words as possible.

3.5. Ethical considerations

Ethical considerations were uppermost in the mind of the researcher throughout the study. For ethical purpose, it was necessary to apply for permission to conduct research in the area, both from the OR Tambo District Municipality Office under the control of the Municipal Manager, and from the relevant chiefs, as already explained under 'entering the field of research'. In rural parts of Eastern Cape it is considered unethical to linger in an area where one is not known. It is necessary that one alerts the local authority – in the case the chief – of one's presence in an area

and seeks his permission to conduct one's business. In addition, one is in need of the chief's protection during a stay in an unfamiliar village or community.

As part of an ethical approach, participants were asked to sign consent forms indicating that they were participating of their own free will and stating that they had a right to withdraw from the study any time. There were two copies of consent forms, one in English and one in *isiXhosa,* allowing the participants to read and sign the form in the language they understood best. Most of the participants were reluctant or unable to read and they all asked the researcher to read and interpret for them – hence only the consent forms written in English were signed. The consent form which was written in *isiXhosa* was only used for cross checking and as confirmation of the contents of the consent form written in English. These consent forms specifically guaranteed confidentiality and anonymity for participants and established a baseline of trust for participants. Confidentiality and anonymity were guaranteed by promising participants non-disclosure of their names and by stating that photographs would be taken only with permission from the participants (parents in the case of children). In the end no photographs were taken. The consent forms also guaranteed that the information would be used only for the purpose of the study and nothing else.

For ethical purposes too, it was imperative to observe the stipulations of the Bill of Rights 28(1)(d) as presented in The Constitution of the Republic of South Africa (1996, p13). The study involved children and the Bill of Children's Rights states clearly that children should be protected from maltreatment, neglect, abuse or degradation. Hence the physical examination of a victim of the illness and the taking of photographs were not tools used in this research, as they could possibly have led to a form of degradation. As has been mentioned above, children are a

vulnerable group to work with, needing parental consent, and so it was deemed best to work with parents and traditional healers who have cared for children with *ukuhanjwa*. Participants were not promised rewards for participating in the study. When they asked how they might benefit from the study, it was important to give honest and authentic responses which would not backfire in the long run.

3.6. Data analysis

The analysis of data was done using the interpretive analytic approach with a detailed thematic analysis, care being taken not to distort information, as cautioned against by Kuhn (1970), Hammersley (1993, pp1-2), Anderson (1996, pp23-29), and Shoko (2011, pp277-292). Anderson states that the interpretive analytic approach is useful in analysing data on human behaviour especially where it involves beliefs and practices, since these are complex phenomena. Additionally, Burrell and Morgan (1979) in Naidu and Ojong (2010, pp96-112) highlighted that the interpretive approach "places the emphasis of explanation in the subjective consciousness of the social participant instead of the objective observer, especially regarding intimate and vulnerable experiences and views of the social actors." Spaces were created for people to tell their stories as a way of accommodating multiple realities as explained by Naidu and Ojong (2010, pp96-112), utilising direct quotations of the participants in their own language as a way of minimising distortion of information. But the researcher realised that it was necessary and beneficial to embrace the advantages of analysing from a critical point of view for purposes of community development. According to Berreman *et al.* (1971, p341), the ethnographer often views what is happening in the research area from a perspective that is different from the perspective of the local person – hence an ethnographer's data analysis and interpretation is often

from a critical point of view. Findings were analysed with reference to the theories which acted as hypotheses of the study, as discussed in the introduction and literature review, and these were either supported or refuted by the research findings. A comparative analysis (Berreman *et al.* (1971, p328) was also employed, although it was not mentioned in the proposal for the study, as five local municipalities' perspectives are involved and a common ground for conceptualisation of *ukuhanjwa* had to be established.

The reason for using the interpretive analytic approach was that the study involved the internal reality of *ukuhanjwa* as the ontology, *ukuhanjwa* as the aetiology and the use of qualitative and ethnographic research methods. The purpose was to help people understand the social interpretation and meaning of *ukuhanjwa* as an illness and aetiology in the Southern *Nguni* context. In-depth explanations based on inductive reasoning together with descriptions of how the illness is socially constructed, were applied for data analysis. Kuhn (1970) points out that evidence for the reality of "spiritual" illnesses is always context-specific and can be understood fully only from within the culture which produces it. The orientation of people within such cultures is spiritual, and their practical knowledge of the transcendent stands outside of the realm of the dominant Western culture.

The implication is that an outsider would find it difficult to ascertain the truth or falsity of a cultural illness or healing theory that arises from such a culture. For this study, conclusions were drawn based upon the consistency of the information as presented by people across a fairly wide geographic area. Consistency was found both in understanding of, attitude towards and practical

healing methods for the illness. The fact that success in healing was invariably attained using this common body of knowledge seemed to attest to the reality of the illness.

Kinship diagrams were used so that the reader would be able to notice at first glance that most of the case study interviews were held with mothers experienced in raising children. The stories and experiencies of these women, so experienced in child-rearing, may be considered authorative. Many were responsible not only for their children but for their grandchildren as well.

3.7. Summary of the chapter

Qualitative and ethnographic research methods were used for the study, covering people in urban, peri-urban and rural areas across five local municipalities of the OR Tambo District Municipality in the Eastern Cape. All socio-economic groups except the very wealthy were reached, and all ages were included.

In-depth interviews were conducted using a written interview schedule for qualitative research, and field notes were used to record observations, facts and conversations. As indicated, participant observation was also done, especially during collection of traditional medicinal plants with the permission of the participants. No photographs were taken for ethical reasons. Four focus group discussions were also conducted taking advantage of the normal gathering days of these groups, which met regularly for purposes of community development. Additionally, various case studies within the same study were conducted for in-depth ethnographic descriptions of events which were believed to be true and accurate.

Parents, both male and female, whose children had experienced *ukuhanjwa* formed the population of the study and the snowballing technique was used to identify such parents, who were grouped into three age group categories. A total of 50 participants were interviewed. Before entering the field, permission was obtained from the District Municipality and a gathering of chiefs; in addition, the local chief of each area was applied to immediately upon entering a community or village. This was done so that protocols would be observed, as a mark of respect, and so that formal protection could be obtained while in an area under a chief's jurisdiction. Care was taken at all times to be sensitive to local customs, to fit in with host families and to be willing to participate in household chores. The researcher's personal experience prepared her for the importance of respect for other people's culture and the fact of cultural diversity. Hence she took the decision to wear long skirts throughout the period of research, to minimise scepticism amongst participants and community members who were traditionalists.

The researcher had to delimit the study area and the scope of research for feasibility purposes, considering constraints on resources and time. The study had certain limitations such as the inability to witness the illness at the time of manifesting, relying instead on eyewitness accounts. For the purpose of trustworthiness and consistency, the researcher conducted all research personally over several visits to the five local municipalities, including one stay with a host family for an extended period of time for the purpose of ethnography in the Nyandeni Local Municipality.

The interpretive analytic approach was used to simplify the complex phenomenon of *ukuhanjwa* aetiology and healing, taking into account the worldview of the people. At the same time the

researcher took full advantage of the critical and analytical tools at her disposal, so as to contribute meaningfully towards the preservation of a body of indigenous knowledge.

CHAPTER 4: *UKUHANJWA*

4.1. Overview

This chapter presents a 'thick description' of *ukuhanjwa* as a 'spiritually-caused' illness. The thick description approach was found to be the most relevant for this study since there is scanty information in the literature on *ukuhanjwa* which would make sense of the illness from the participants' worldview. Geertz (1994, pp214-223) in Ponterotto (2006, pp538-543) explain 'thick description' as a means of capturing the thoughts, feelings and observed social actions and interactions of the researched people; in this case, the Southern *Nguni* people of the ORTDM.

Denzin (1989, pp91-98) in Ponterotto (2006, pp538-542) mentions twelve types of 'thick description', *viz* the micro, macro, historical, biographical, situational, relational, interactional, intrusive, incomplete, glossed, purely descriptive, and descriptive-interpretive. In this chapter, biographical, situational, relational, and interactional 'thick descriptions' by both the participants and the researcher have been employed to render more information and contextualise the manifestation of *ukuhanjwa*. The biographical 'thick description' has helped to locate and contextualize the scenario for various categories of participants, and to measure the level of knowledge transfer from generation to generation. The situational and relational 'thick description' has helped to contextualise the situation in which the victim of *ukuhanjwa* and his or her mother or caregiver finds herself/himself and to present how the caregivers understand the illness. The interactional 'thick description' has also assisted with revealing interactions between people, resulting in a sharing of knowledge and experiences and the process of enculturation. All

four of these types of 'thick descriptions' are employed in some case studies, and two or three of them may have felt to be sufficient in other case studies.

The chapter presents identifiable symptoms of *ukuhanjwa,* as understood and recognised by the Southern *Nguni* people of the ORTDM, and elaborates on the conceptualisation and social construction of *ukuhanjwa*. It suggests that the conceptual framework for the illness is the basis for the belief that *ukuhanjwa* is a spiritually-caused condition and an example of an '*abantu*' illness or '*ukufa kwabantu*' or *ingulo yesintu*.

'*Abantu*' illnesses are believed to be spiritually caused and therefore medically invisible when examined according to the biomedical health system – hence the continued use of traditional (indigenous and indigenized) healing methods. Ngubane (1977) in Urbasch (2002, p11) explained "*abantu*" illnesses or "*ukufa kwabantu*" as illnesses which are believed to be caused by witchcraft, withdrawal of protection by ancestors as a result of bad behaviour, spirit possession or pollution (*isimnyama*). Two forms of pollution can be found; intended and unintended (Ngqila, 2002). Intended pollution is a deliberate action, intended by a witch, who uses familiars or other forms of evil spirits to harm someone. Unintended pollution is the random, unplanned action of an evil spirit or familiar, which may linger after a witch's death and begin to act independently. *Ukuhanjwa* is believed to be of the latter type.

Familiars have been defined by Petrus and Bogopa (2007, p3) as "supernatural spiritual agents that can only be controlled by a witch (*igqwirha*) who has created them", but the evidence as

presented here suggests that, in the case of *ukuhanjwa* at least, familiars act independently at times.

Kroll-Smith and Floyd (1997), Barker (2005), Brown (2007) in Conrad and Barker (2010, p70) suggest that some illnesses have a cultural meaning which is "medically invisible" even in this era of high-tech biomedicine, and that this is because medical knowledge is constructed and developed by societies and not necessarily a fact of nature. Conrad and Barker (2010, p67-70) refer to illnesses with cultural meaning ('*abantu*' illnesses) as socially constructed illnesses depending for conceptualisation on a particular cultural group. The foundations laid by older members of the society for the conceptualisation of issues within their contexts serve as human motivation for younger members to believe in socially constructed models such as *ukuhanjwa* as a spiritually-caused illness. This follows the argument by Strauss (1992, p11) that "it is not enough to know what information or knowledge people are exposed to, but also to understand how they internalise the information" resulting in the final conceptual framework either of an individual or of a community. This idea has been supported by Davis-Floyd (1990, p276) who says that the conceptualisation of social relations, activities and interactions play a significant role in shaping responses of individuals to a cultural model such as a belief in the spiritual causation of '*abantu*' illnesses. Thus, people's responses to cultural models are often influenced by societal beliefs, coupled with their own personal experiences.

Lastly, the chapter also includes an aetiology of the illness in question as conceptualised by the Southern *Nguni* people of the ORTDM. The conceptual framework for the aetiology of *ukuhanjwa*, as contextualised by the Southern *Nguni* people, has been drawn from the

attributional theory of Vaughn, Jacquez and Baker (2009, pp64-67), as well as from that which has been internalised by participants as a result of information imparted to them by diviners and elderly people.

4.2. Description and identifiable symptoms of *ukuhanjwa*

The Southern *Nguni* of ORTDM described *ukuhanjwa* as an 'attack' on a person, young or old, by 'familiars' (*izilwanyana zokuthakatha*), literally meaning demonic animals used by witches, which penetrate the body through any bodily opening, resulting in certain identifiable conditions. The Southern *Nguni* people make a distinction between two forms of *ukuhanjwa*, that is, the mild and the severe forms of the illness. The mild form manifests itself as red patches on the lips, around the outer lining of the anus and the genitals, and a wide open anus. The victim could be a child or an adult since *ukuhanjwa* has no age limit, but it usually affects children or infants. The victim is always sleepy and, in the case of babies, their cry is always indicative of weariness rather than of pain or discomfort. Indeed, anecdotal evidence suggests that the mild form can present with no pain at all. This form is fairly easy to control and is usually dealt with by the mother or caregiver using traditional medicines.

The severe form of the illness attacks the upper parts of the body as well as the lower parts, with the sinking of the fontanel, the neck losing muscle strength, regurgitation of feeds (*uxakaxa*) and thick saliva through the mouth. Vomiting and diarrhoea are common at this stage. The anus would be particularly wide open, to the point where one would be able to see up into the intestines, and even the genital parts would be open. There would be a ring of red patches around the anus and genitals and pus may emit from both the nose and anus of the victim.

The Southern *Nguni* people of the ORTDM expressed their fear of severe *ukuhanjwa*, stating that, since it starts in the upper parts of the body with symptoms that could indicate a variety of illnesses, it is very difficult to identify. The most common response of the Southern *Nguni* when they suspect *ukuhanjwa* is to check the anus of the victim; whether or not it is wide open. They said that, once the victim reaches the stage of losing muscle strength in the neck, there would be no way of recovering, and the victim would die.

A young 19 year old mother, Nathi*, with her 2 year-old baby, was an interviewee from the King *Sabatha Dalindyebo* Local Municipality (KSDLM). Her family is represented in a kinship diagram below:

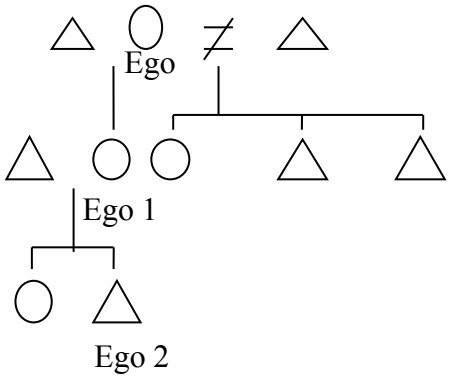

Figure 1: Kinship diagram for Nathi*'s (ego 1's) family in the KSD.

As shown in the diagram, Nathi* (ego 1) has a daughter and a son, and is herself the eldest child of four. She was born out of wedlock, after her mother, Zodwa* (ego) became divorced from her father and returned to her own father's home with her existing children. Here she was not

welcomed by her sister and experienced much rejection and conflict, resulting in her having to leave and construct her own home in the village of Qokolweni.

The researcher came across Nathi*'s mother, Zodwa*, on the road whilst she was still trying to decide whom to approach as her contact person in Qokolweni. The researcher approached the woman and explained the purpose and rationale of her visit to the village, enquiring whether she would be prepared to act as mediator between the community and the researcher. Zodwa* and the researcher then went together to Zodwa*'s home to meet with her family. On reaching Zodwa*'s home, it was evident that they had just moved into the new four-roomed home as it was still under construction, with only two rooms completed. All her children were at home, busy with their chores, which gave the impression that Zodwa* had done her part in instilling a sense of responsibility in her children. In the room where interviews were conducted, only Nathi* was present. According to tradition, children are not supposed to be in the same room as older people when there is a visitor. Nathi* enjoyed this liberty because she was a mother, already working, and renting her own place as an independent woman – hence recognised as an adult by her mother and by her community.

Zodwa* convinced Nathi* to be the contact for *Qokolweni* location in the KSDLM and to assist the researcher in contacting other relevant participants in the area. Nathi* readily agreed. She was working as a teacher at a local Junior Secondary School, receiving a very basic salary as a School Governing Body employee rather than as an employee of the Department of Education, which would have fetched a higher salary. At the time of the interview, she was visiting her mother, having her own rented accommodation in Mthatha where she lived with her two

children. Nathi* and her mother were both willing participants in interviews. Nathi* had experience of *ukuhanjwa,* in this case through her baby son. Nathi*'s mother explained that when the illness manifested, Nathi* had not recognized the symptoms, which Nathi* herself explained in the following way:

> *Owam umntwana waqala ngokuba bomvu imilebe nomngxuma lo weempundu. Wayethanda ukulala nokukhala kakhulu ebonisa ukungabi namandla*.
>
> My child started by having red patches on the lips and anus. He was always sleeping and had a weary cry signifying lack of energy.

She went on to say that, as she did not recognise the symptoms, she took the child to her mother to have a look at, whereupon her mother identified it as *ukuhanjwa*. She prepared an infusion of traditional medicinal plants and applied this to the affected parts. Zodwa* explained that when *ukuhanjwa* is suspected it is imperative to start healing the baby before attending to any other issue such as explaining the illness to the mother or caregiver – one needs to act fast. Nathi* and her mother had a very good mother-daughter relationship and Nathi* trusted her mother's opinion and experience – hence she did not object to her mother's treatment. Zodwa* further explained that the illness is not generally talked about until it strikes someone, and that this lack of familiarity with the illness contributes to the irregular pattern of enculturation within young mothers. Most would not know how to treat the illness. This impacted on the application of preventive measures which are often not considered, as discussed in chapter 5.

In the Port St Johns Local Municipality (PSJLM), the researcher encountered a group of women just leaving a funeral. Some were from PSTLM and others were from *Nyandeni* Local Municipality (NLM). They were very willing to share their experiences of *ukuhanjwa* and

invited the researcher to accompany them as they walked home. After some time they suggested that they sit and chat in a comfortable place on the side of the road, resulting in a satisfyingly long, uninterrupted conversation.

One of the women was a 27 year-old mother, Nobom*, with a one and a half year-old baby. She lived in a village near Port St Johns and had a Junior Secondary level of education. Nobom* confidently described symptoms of *ukuhanjwa* as identified in her own child:

> *Uqala ngokumatha umntwana, amehlo ayekelele, ahlale elele engathandi kutya, othukelane xa elele*. *Amaxesha amaninzi unesi sikhalo sityhafileyo esibonisa ukuphelelwa ngamandla*. *Uba nabo nobushushu kangangokuba ngamanye amaxesha ude axhuzule xa bumongamele*. *Xa enqikwa ngasemva ezimpundu, kufikwa ebomvu ngaphakathi nangaphandle, kanti nangaphambili ngokunjalo*. *Uye abonakale ngathi uqalwa sisitshitshilili samaqhakuva azunguleze umngxuma lo weempundu esithi sibizwe ngokuba sisilonda*/*inxeba*. *Uyavuleka umngxuma lo weempundu kubonakale amathumbu ngaphakathi*. *Xa umseza ubisi, lungena emlonyeni luyophuma ezimpundu lunjalo lungeyongqaka nje ngophawu lokuba belungaphakathi emzimbeni womntwana*. *Ide yonyuke le nto izomophula ilungu lentamo apho athi abhubhe khona*.
>
> The child begins by being despondent, heavy-eyed, always sleepy and not wanting to eat. It would often appear as if something was frightening him in his or her sleep. Most of the time, the child would have a weary cry, signifying lack of energy. The child would also have a high temperature and it happens that sometimes when the temperature becomes exceedingly high, the child would experience convulsions. When one checks the anus of the child, the area would have red patches inside and out. Same applies for the genitals

> which would also have red patches. A ring would be formed from patches of small pimples around the anus which is usually referred to as the 'wound'. The anus becomes wide open such that when looking through it, one is able to see the intestines inside. When one is trying to feed the baby with milk, it would run from the mouth to the anus with no indication that it has been mixed with the digestive juices from the inside of the baby. This thing would even go up to break the neck causing it to lose balance up to a point where the baby would die.

As already explained in the methodology, the researcher stayed at the home of the contact person, Nosebenzile*, a 71 year old woman, at NLM for the purpose of ethnographic research. Nosebenzile*, as a grandmother who took care of most of her grandchildren, would easily notice when her grandchildren were sick and identified *ukuhanjwa* in one case. She gave the same identifiable symptoms as the rest of the participants and explained that:

> *Umzukulwana wam owayeneenyanga ezintathu wayenesikhalo esingapheliyo esiyinto enye yozengezenge, engakhaliswa bubuhlungu phofu, nto nje izizimbo zokuba nesi sigulo sorheqo*.
>
> My grandchild of three months had a nagging cry, not because of pain but as an indication of the *ukuhanjwa*.

Nosebenzile* introduced the researcher to a group of women participating in a Home-Community-Based Care (HCBC) project. One of them, 36 year old mother, Siziwe*, gave information on the severe form of the illness:

> *Xa limdle ngasentla angafa ngoba akakhawulezi ukubonwa kwaye ngamanye amaxesha uye angavuleki apha ngasemva ekuyiyona nto adla ngokubonwa ngayo ngokukhawuleza.*

Ude angakwazi nokuhamba xa limdle ngasentla ngoba utshona nofokotho olu. Kanti ke owam umntwana wayede ephuma ububomvu ngeempumlo nangasemva. Wasinda nje kuba isigulo singazange sifike entanyeni nasefokothweni.

When the child has been attacked on the upper parts of the body, there are high chances that the baby will die, because it is not easy to quickly identify such symptoms, especially because sometimes the baby would not have the wide open anus which is an easily identifiable symptom of the illness. The child would lose balance and become unable to walk, since he would have a sunken fontanel. My child even had pus through the nose and the anus. The only thing which saved him was that the illness did not affect the neck and the fontanel.

A visit was also paid to Lothana location, *Mhlontlo* Local Municipality (MLM) where Nokwakha*, a 51 year old mother (ego 1), became the local contact person and also participated in interviews, since she had experience of *ukuhanjwa* in her child. She was married with five children. She and her husband were self-employed at the time of time of the interview, with a small business selling food to learners at a local school. Both the mother and the father had a Senior Secondary School level of education. It was Nokwakha*'s last-born daughter, indicated in the kinship diagram below as ego 2, who had frequently been a victim of *ukuhanjwa*.

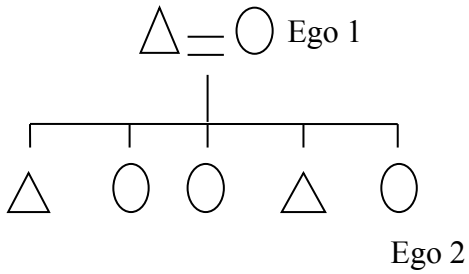

Figure 2: Kinship diagram for Nokwakha*'s (ego 1's) family in the MLM.

This 51 year-old mother acknowledged that she had found it difficult to relax as a mother, since children, who sleep more than adults, are so frequently the targets for familiars, who attack when the victims are asleep or suffering from some other, unrelated illness. She said, however, that her child had never reached the stage of severe *ukuhanjwa*:

> *Xa imdle ngasentla iyamgabhela ngaphakathi imenze abe noxakaxa namathe ajiyileyo*. *Umnwe uvele uzihambele nje ezimpundu*. *Owam uhlala edliwa ngezantsi futhi ndimbone kwangoko ndimthofiyele ngamayeza esintu ngoko nangoko. Andililindi ilishwa*.
>
> When the baby has been attacked on the upper parts of the body, she would have thick acidic ejections, with thick saliva. A finger goes through the anus with ease. Mine was always attacked from the bottom and I would always notice her at the early stage and immediately dose her with traditional medicine. I do not wait for the misfortune.

All these descriptions for *ukuhanjwa* reveal the level of fear the Southern *Nguni* people have for the illness – hence their response as illustrated in the model on the conceptual framework of *ukuhanjwa*. As has been mentioned before, the knowledge on how to identify *ukuhanjwa* is transferred by elderly people to the younger generation with the intention of minimising deaths,

focusing mostly on infant mortality but from their own contextual framework which cannot be easily understood by an outsider.

In trying to understand the nature of *ukuhanjwa,* one can consider the argument by Barker (2003, p47), that knowledge has always been a matter of perspective, which is not pure or neutral but is always from a particular point of view, depending on the dominant point of view of the ruling culture. In this era of globalisation, the most dominant knowledge and theories in the area of health and illness are that of the Western countries, with their biomedical system of health. The theories of health that link illness to spiritual causes are regarded as theological, traditional or metaphysical by those who subscribe to the biomedical health system, and as such, outside of their sphere of interest. Barker (2003, p51) recommended that truth should be understood to be a "social commendation rather than an accurate picture of reality". From this perspective the conceptualisation of *ukuhanjwa* by the Southern *Nguni* people is difficult to dispute and dismiss completely. The implication could be that the biomedical health system should be afforded an opportunity to explore the possibilities of *ukuhanjwa* through examination of victims and a preparedness to listen to the observations and perceptions of their caregivers. This could assist in broadening the biomedical knowledge about the illness, with the differing perspectives complementing, rather than competing with one another.

Currently few of the Southern Nguni people interviewed favour biomedical centres as sources of help when faced with *ukuhanjwa*, since they believe that the causes and cure for the illness is obscured to practitioners of other medical systems. Unfortunately, the particular cultural practice of leaving not only the diagnosis, but also the description of symptoms, to the doctor to discern

on his own, contributes to misunderstandings and disappointment for the caregivers who take their children suffering from *ukhanjwa* to Western-trained doctors. The interviewees who had visited biomedical health centres for mild *ukuhanjwa* assumed that the doctors would know both the symptoms and the diagnosis, as this is customary when visiting a diviner. As a result, they would leave disappointed, advised to offer an analgesic such as Panado (trade name) i.e. paracetamol or acetaminophen, which they used while continuing with traditional healing methods. As a result of this conviction that the true nature of the illness is hidden to Western-trained doctors, most Southern *Nguni* people would only visit the biomedical health centre when the illness has escalated to the level of severe *ukuhanjwa.* At this point doctors would perceive the wide opening of the anus as the effect of severe diarrhoea or of sexual assault. It most cases the victim would die, much misunderstanding would remain for both doctor and caregiver, and an opportunity would be lost for both parties to add to their body of knowledge.

It would be natural, given the symptoms of *ukuhanjwa*, to assume that the illness could be some form of rectal disorder. Merck Manual Home Edition (2013) mentioned four forms of anal and rectal disorders, that is, proctitis, anorectal fistula, anorectal abscess and rectal prolapse, but none has a description similar to that which has been given for *ukuhanjwa* by the Southern *Nguni* people of the ORTDM in the Eastern Cape. Proctitis has been described as the inflammation of the lining (rectal mucosa) of the rectum whilst rectal prolapse is the painless protrusion of the rectum through the anus. Anorectal fistula has been described as an abnormal channel that leads from the anus or rectum to the skin near the anus but occasionally to another organ, such as the vagina. Anorectal abscess is known to be a pus filled cavity caused by bacteria invading a mucus-secreting gland in the anus and rectum.

In all these illnesses, swelling, pain, protrusion of the rectum through the anus, and inflammation of the lining of the rectum are mentioned. None of these match the description of *ukuhanjwa*. With *ukuhanjwa*, the wide opening of the anus, to the point where one can see the intestines, is the most prominent description put forward. At the most severe stage of *ukuhanjwa* there is mention of pus which is released, tempting one to link the illness to anorectal abscess. But in the case of anorectal abscess, the pus is not said to be released, but fills a skin cavity, and can only be removed by cutting and draining the abscess or tumour (*ithumba*).

Ukuhanjwa could be another anal and rectal disorder which has not been identified by the biomedical health system, since caregivers rarely take the victim to biomedical centres when the only symptom is the wide open anus. When they do decide to take the patient to a biomedical health centre, they do not mention the symptoms as identified by them, and indeed, in such cases the illness is usually too advanced for successful treatment.

Another symptom which has been mentioned by the Southern *Nguni* people is that of the skin disorder around the outer layer of the anus as well as the tip of the genitals. None of the pictures of skin disorders in babies (2014), as indicated in the Google Search engine, came close to the description of *ukuhanjwa,* as described by the Southern *Nguni* people of the ORTDM.

4.3. Conceptualisation and social construction of *ukuhanjwa*

It is understood that the social construction of illness emanates from the shared experiences and worldviews of a society, which are passed on to members for a common understanding and

conceptualisation as a cultural group. Conrad and Barker (2010, p67) and Lock and Strong (2010, p6) share a view that illness is a socially constructed issue, depending on the worldview of the cultural group in which it manifests. Davis-Floyd (1990, p275) asserted that the forces shaping society's conceptualisation and responses to certain stimuli stem from their conceptual foundations. Thus we see that The Southern *Nguni* people of the ORTDM socially construct *ukuhanjwa* so as to be able to attach a name to the illness and deal with it based on their common conceptualisation as a society. Their responses to *ukuhanjwa* reveal their conceptualisation of the illness based on their experiences, social relations, activities and interactions, as well as their internalisation of the information on the illness as transferred to them by their elders. Although some of the young Southern *Nguni* people could have internalised their experience of *ukuhanjwa* and found it to have no meaning according to their Western values as acculturated youth, they found themselves, together with their children, exposed to the phenomenon, and possibly could not attach any Western name to it. For most of the young mothers, the trust they have in the opinion, knowledge and experience of their mothers and grandmothers, coupled with their own observations of the illness, cause them to submit to the help offered to them – that of the application of traditional medicine, acculturated as they are.

The Southern *Nguni* people of ORTDM hold a strong belief that witchcraft and other forms of supernatural activity have the potential to harm them. In order for the younger generation to avoid being accused of ignorance and disregard for cultural beliefs, and to prevent illness and death, they submit to their elders' guidance on how to deal with the illness.

This takes the discussion to the functionalist approach of studying societies as espoused by Malinowski (Moberg 2013, p191), in which emphasis is placed on people's cultural practices (i.e. actions) as a means of meeting their individual needs. Unlike Malinowski, Radcliffe-Brown's approach in studying society emphasised social solidarity and social structure which is maintained through people's actions, irrespective of their individual values, individual interests or even individual goals (Moberg, 2013, p183). This literally implies that people forfeit their individual needs for the sake of social cohesion.

In this regard, the manner in which Southern *Nguni* people of ORTDM have conceptualised *ukuhanjwa* follows Malinowski's approach of functionalism. The social construction of *ukuhanjwa* could be linked to the functionalist approach when taking into consideration Davis-Floyd's (1990, p275) suggestion that before a person can conceptualise any form of cultural model and respond to it, he/she first considers, internalises and interprets his/her experiences of the cultural model, as well as knowledge and information gained from his or her elders. This leads to an interpretation of and response to the stimulus that suits the needs or interests of the individual. Thus it does not follow Radcliffe-Brown's model which seems almost to discount the personal decsisions of the individual caretaker or afflicted person. Individuals are subject to strongly conflicting messages regarding health care, with the Department of Health advocating the use of biomedical health centres and traditionalists - often family members - advocating traditional healing methods for cultural or *abantu* illnesses. Younger people have to make up their own minds about these matters, based on what they have internalised and believe to be true.

An individual who has not been taught the identifiable symptoms of *ukuhanjwa* from the Southern *Nguni* people's perspective could interpret the illness from a different perspective and respond by applying, for instance, biomedical healing methods, and then find himself/herself being blamed for the death of the patient due to ignorance, regardless of whether the patient presented too late for medical intervention to be of any help. The expectation of the Southern *Nguni* elderly people would be for the individual to inquire from the elders, those repositories of traditional knowledge, when he or she comes across a strange or unfamiliar illness.

There is often an assumption in the biomedical fraternity that *ukuhanjwa* is constructed for social solidarity so as to cover up rape or molestation, which could have been performed by a family or community member. But the Southern *Nguni* people have refuted that assumption through their conceptual foundation of *ukuhanjwa* as has been discussed in the paragraphs to follow. The Southern *Nguni* people of ORTDM have a different conceptualisation of *ukuhanjwa* based on identifiable symptoms, their conceptual foundation and the aetiology of the illness in question. Names for the illness indicate the symptoms, *viz ukuhanjwa* or *ukudliwa* (spiritual penetration), *ukwebiwa* (stealing of the soul) or *isilonda* / *inxeba* (wound). The 'attack' is referred to as *ukuhanjwa*/*ukudliwa* since the wide opening of the anus is linked to penetration by familiars (*izilwanyana zokuthakatha*). Some refer to the illness as *ukwebiwa* (stealing of the soul) since the victim becomes lazy, sleepy, and inactive. The illness is sometimes referred to as *isilonda* / *inxeba* because of the pimples which join together to form the 'wound' around the anus. Sometimes the illness is referred to as *urheqo* which simply means coming into spiritual contact with familiars. The 'attack' by or 'coming into contact' with familiars results in the condition associated with *ukuhanjwa* as conceptualised by the Southern *Nguni* people of ORTDM.

One example of the Southern *Nguni* interpretation of *ukuhanjwa* is that of a middle-aged mother of four children, Nobathembu*, who narrated her personal experience of the illness. She was 46 years-old at the time of the interview, had a Senior Secondary level of education, and has held various managerial positions at work. She resided in one of the more affluent suburbs of Mthatha, recognized as being for the 'elite'. Her parents too were educated, according to Western standards, with her father having been a member of parliament in the former Transkei. She indicated that she had suffered an attack of the illness as an adult. She had had no previous knowledge of the illness and so did not recognize the symptoms, until a friend explained *ukuhanjwa*:

> *Ndathi xa ndizama ukuzosula, ndeva ukuba umngxuma lo weempundu uvuleke ngendlela engaqhelekanga. I* toilet paper *kunye neminwe yam yayinokungena nje ngokulula kangangokuba wawuvulekile umngxuma weempundu. Ndandingaqhinwanga, futhi nethumbu lam lalingaphumelanga ngaphandle, ngumngxuma nje owawuvulekile uthe ng'a. Ufanele umince uvaleke uthi mba kaloku lo mngxuma xa liphumile ilindle, ungashiyeki uvuleke ngohlobo owawuvuleke ngalo owam ngokungathi wawusowuphelelwe kukuzilawula. Ndandingeva buhlungu kwaphela, kangangokuba ndaye ndaxakwa nokuba ndingafika ndithi nditheni khona xa ndinokuya kwagqirha. Ngelo xesha ndandingenalo ulwazi lokuba kwenzeka ntoni kodwa ndandiyazi ukuba ikhona into engalunganga*.
>
> When I tried to wipe, I felt that the anus was wide open in an unusual manner. The toilet paper together with my fingers would have easily gone through considering the manner in which the anus was wide open. I was not feeling constipated, even my rectum had not

> protruded to the outside, only the anus was wide open. The anus is supposed to close tightly after the ejection of the stools, and not remain wide open the way mine was, as if it had lost control. I was not feeling pain at all, so that I became confused as to what I would report as my illness should I decide to visit the biomedical physician. At that time I had no knowledge of what was going on, but I knew there was something wrong.

One would assume from this woman's biographical description that she might have adopted Western values and have opted for Western biomedical intervention for her condition. But she could not understand the nature of the disorder and found herself refraining from visiting the biomedical practitioner, since the disorder did not make sense to her. She associated illness with pain, which was missing in her experience. When she heard about *ukuhanjwa*, she became convinced that she suffered from the condition, based on the identifiable symptoms.

The same conceptualisation of *ukuhanjwa* cuts across all ages and is held by both males and females among the Southern *Nguni* people of the ORTDM. One of the examples came from *Ingquza* Hill Local Municipality (IHLM) which was also visited to interview some participants. Nokuzola*, aged 59, was pleased to assist as a contact person in the research area and also became one of the participants together with her husband, Zakhele*, since their granddaughter (ego3) had experienced the illness. Nokuzola*'s mother had been a friend to the mother of the researcher. Nokuzola*'s family was big, with a number of children and grandchildren, as illustrated by the kinship diagram below:

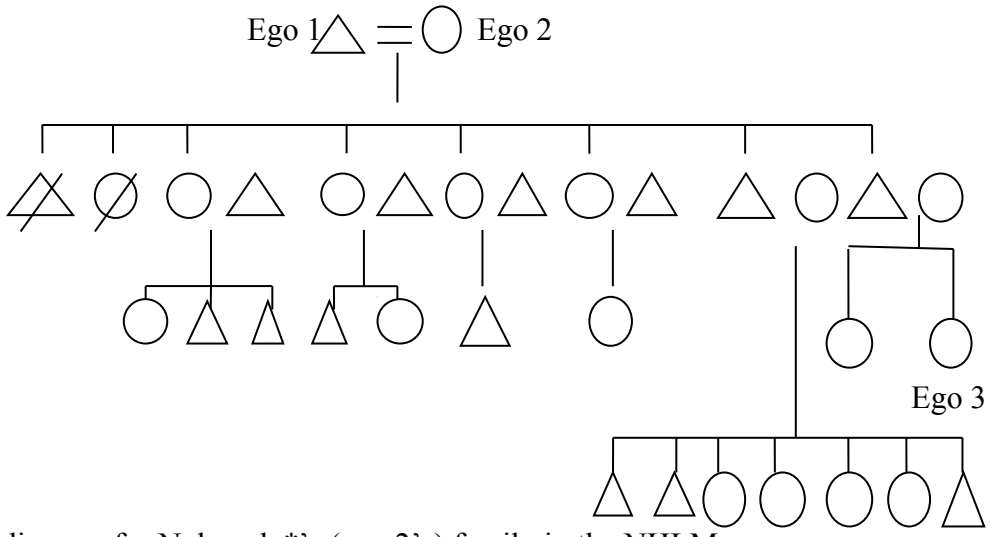

Figure 3: Kinship diagram for Nokuzola*'s (ego 2's) family in the NHLM.

Nokuzola and Zakhele's granddaughter, the child of one of their sons, suffered an attack of *ukuhanjwa*. An interview with Zakhele* revealed that he did not recognize his sons' children as part of his family, in contrast to his wife, who did recognize them. She healed her grandaughter, using traditional medicinal plants that she learned about from her own father, who had been a diviner.

During the researcher's second visit in the area for more qualitative interviews, Zakhele* took the researcher to the headman's homestead so that he would be aware that there was a visitor in his area. This is a cultural requirement when spending any amount of time in a village that is not one's own, as a mark of respect, and so that headmen feels obliged to offer protection to the visitor. It was during this visit that Zakhele, together with the headman and his wife, spoke at length to the researcher. Zakhele*, who is 90, reiterated the symptoms of *ukuhanjwa* that others had given:

Isibunu siba bomvu kakhulu kwaye sivuleke kubonakale amathumbu ngaphakathi, namehlo atshone. Isibunu namehlo zizona ndawo abonakala lula kuzo ukuba unesi sigulo.

The anus becomes red and wide open, showing the intestines inside, and the eyes are sunken in. The anus and eyes are the parts with easily identifiable symptoms for the illness.

Even some of those who have assumed Christian values, including those who consider themselves charismatic Christians, have a deep and traditional understanding of the illness, with the same conceptualisations as the rest of the members of the Southern *Nguni* society of the ORTDM. The only difference with those who identify as Christian is in their approach to healing, which would be characterised by cultural modernity, featuring syncretism, resulting in their utilising indigenized rather than indigenous healing methods, together with Christian prayer. A typical example is that of the use of Genuine Seal Oil which will be discussed further in chapter 5.

Enculturation, acculturation and conceptualisation depend on the influence of the people with whom one is constantly surrounded, so that it is not surprising to find shared beliefs and values in a given geographical location. Sometimes, despite the influence of modernity, people insist on maintaining a traditional understanding of illness as a means of explaining the mysterious, and as a means of retaining an identity in the face of rapid modern or Western acculturation. This is common in urban environments where rapid modern or Western acculturation is perceived as a threat to cultural identity.

The conceptual foundation and the description of the identifiable symptoms of *ukuhanjwa* formed the basis for the conceptualisation and social construction of the illness by the Southern *Nguni* people of the ORTDM. Functionalism is the appropriate approach in contextualising *ukuhanjwa* within the Southern *Nguni* cosmology. Individuals use traditional healing methods as advised by their elders in order to overcome fear of the illness or death, to demonstrate respect and trust in the knowledge and experience of elderly people and to avoid blame for the death of the victim of *ukuhanjwa*. At the same time they appear to be defying the expectations of the government in considering biomedical healing methods as the first choice for any form of illness. Conceptualisation of *ukuhanjwa* was also based on personal experience, either in one's child or neighbour's child or in oneself. A model below illustrates Malinowski's functionalist approach of the conceptualization of *ukuhanjwa* by the Southern *Nguni* people of ORTDM:

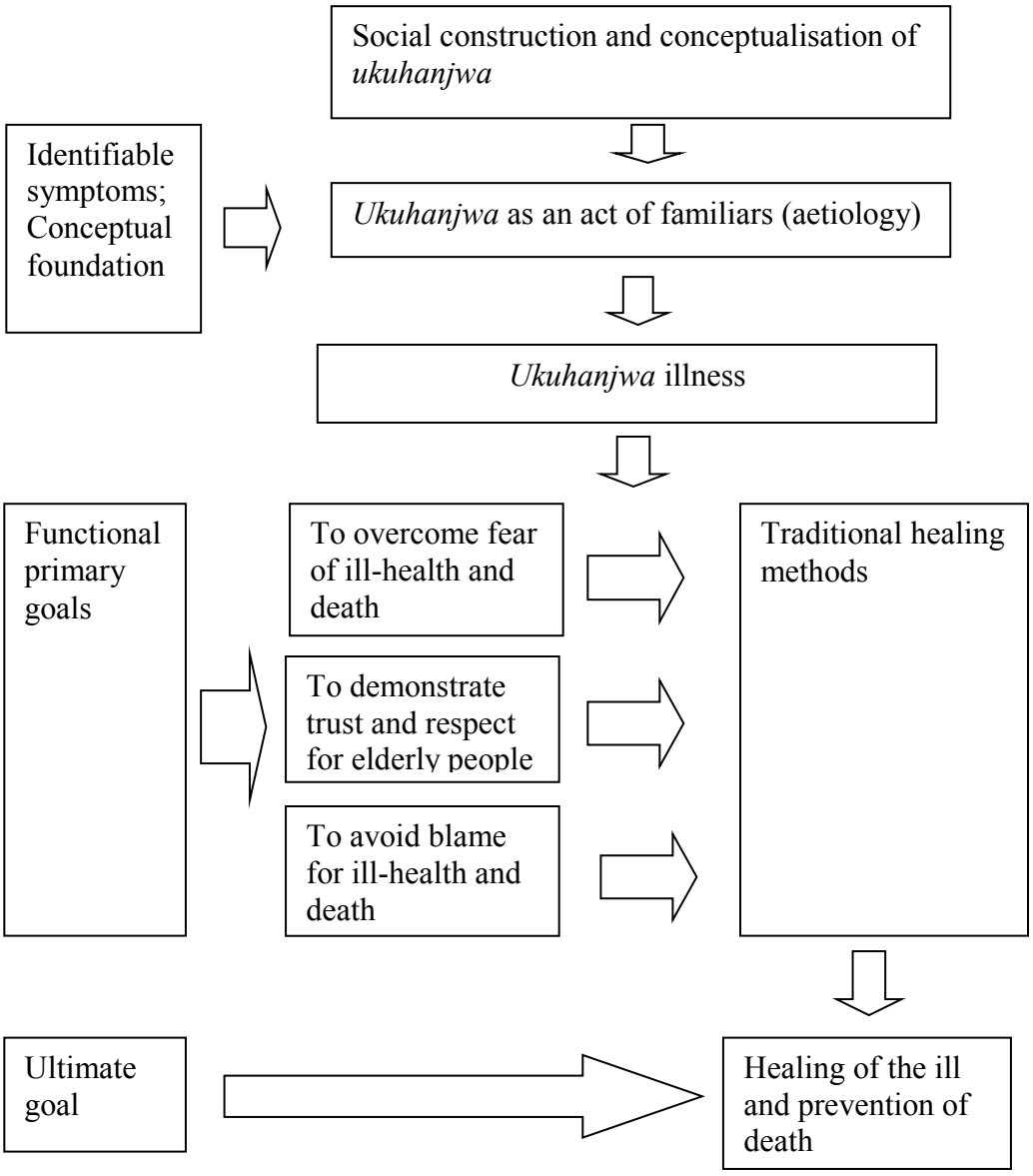

Figure 4: Conceptual framework for *ukuhanjwa*.

Overcoming fear of illness and death, demonstrating respect for the elderly people, and avoiding blame for ill-health and death seemed to be the most immediate and urgent individual obligations and interests to fulfil as functional goals, with the belief that the ultimate goal of healing illness and preventing death is bound to happen. Regarding the assumption which was presented in chapter 1, the conceptual framework developed from the functionalist theory confirmed that those who are still continuing with traditional healing methods for *ukuhanjwa* and other cultural

illness are demonstrating their respect and regard for the indigenous knowledge they gained from their elderly people. Additionally, there are also those who continue with traditional healing methods because of their personal experience, which seems to prove the verity of their beliefs. The small fraction of participants who did not believe in the efficacy of traditional healing methods and the contextual truth of witchcraft theories demonstrated the power of accculturation. They have not experienced the elderly people's theories on *ukuhanjwa* and witchcraft to be true, and have made up their minds based on current, Western influences rather than traditional influences.

Societies which believe that witchcraft and other forms of supernatural activities are real and affect their lives have their own means of dealing with the consequential afflictions, and have not found any means to authenticate their claims to Western minds who strongly believe in a scientific, evidence-based biomedical health system. Belief in witchcraft is dismissed out of hand by the biomedical health system. As a result, all the illnesses which cannot be explained by the biomedical conceptual framework are assigned a spiritual cause, either as the work of witches and their familiars or of ancestors in their anger towards the victim or relatives of the victim. This idea is supported by Helman (2007, p7) who asserts that in some societies, misfortunes are blamed on the supernatural forces of ancestors or malevolent spirits of witchcraft and sorcery. It is these spiritually-caused illnesses which are referred to as "theological illnesses" (Anderson, 1996, pp23-29) by those who subscribe to the biomedical system of health, since it is so difficult for them to analyse these illnesses from the biomedical perspective. Out of 50 participants interviewed, 48 (96%) believed in *ukuhanjwa* as an authentic illness. 44 (88%) participants truly believe in the existence of the illness as a result of their personal experience and 4 (8%)

participants had the same conceptualisation because they trusted and respected the knowledge and experience of their elders. The remaining 2 (4%) participants believed in biomedical healing methods and prayer more than in traditional healing methods because of the Christian influence.

4.4. Conceptual foundation for *ukuhanjwa*

The conceptual foundation for *ukuhanjwa*, as explained by the Southern *Nguni* people of ORTDM, is entirely related to their spiritual understanding of life and a cosmology that is more interested in 'how' an illness came about than 'who' caused the illness. The general indigenous understanding among the Southern *Nguni* people of the ORTDM is that a child is not supposed to be ill or to die at such an early stage of life and that the existence of serious illness is therefore an indication that something is seriously disordered in the spiritual realm.

It has already been explained under the social construction of *ukuhanjwa* that the 'attack' is referred to as *ukuhanjwa*/*ukudliwa,* which is understood as the spiritual penetration of the familiar into the body of the victim through the bodily openings. This is how it is explained to the younger generation by the elders, who inherited the understanding from their elders. Ancestors are believed to have originally consulted diviners in search of answers regarding this illness, as it has always been regarded as something strange and difficult to understand. Diviners would have informed them that the condition was caused by familiars which invaded the victim, and would have been able to describe the symptoms in some detail to the caregiver without the caregiver having to divulge such information herself.

The idea that *ukuhanjwa* could be simply an indication of rape or sexual molestation was dismissed by all the Southern *Nguni* people interviewed for this study. The common understanding is that the opening of baby's vagina would be larger than the width of an adult's middle finger in the case of rape or molestation, whereas only the nail of an adult's finger fits in the case of *ukuhanjwa*. Another understanding by the Southern *Nguni* people of the ORTDM was that there would be blood, semen and pain around the anus and genitals in the case of rape or molestation, whereas none of these are evident in the case of *ukuhanjwa*.

Nozamile*, a participant from the PSJLM, was a married mother with three children, two sons and one daughter. She confirmed the clear distinction between what is understood as *ukuhanjwa* and what is recognised as sexual assault:

> *Ubuntombi bosana bungangehafu yozipho lomntu omdala xa engadliwanga. Xa umntwana edliwe, ubuntombi bakhe buba ngangozipho, ukanti xa edlwengulwe, umnwe uphantse ungena wonke apha ebuntombini bakhe, nto leyo ethetha ukuthi uzipho lungena kude kudlulele enyameni yomnwe. Xa edliwe zizilwane, umntwana ude ahambise abe nalo noxakaxa. Ngamanye amaxesha, xa ebonwe kade, ude abole abe nobubomvu. Owam umntwana zange ade afikelele apho noko. Ndamfumana edliwe nje apha ngasemva engekabi nobuzaza kangako*.
>
> The size of the baby's vagina is half of the nail of an adult person when the baby has not been attacked by the illness. When the baby has been attacked by the illness, the vagina would be the size of a nail of the adult person unlike when the baby has been raped the baby's vagina would be more than the size of the nail of an adult person. When attacked by familiars, the baby would also have diarrhoea

and regurgitation of feeds. In some instances, the baby would even have pus. My child never reached that level. I found her anus attacked though the damage was not that much.

Both Nozamile* and her husband were not working at the time of the interview and struggling to make ends meet. They were living together with their children and with the husband's mother who was 80 years of age and whose pension grant was the only source of income for the whole family. Nozamile*'s family is indicated in the kinship diagram below:

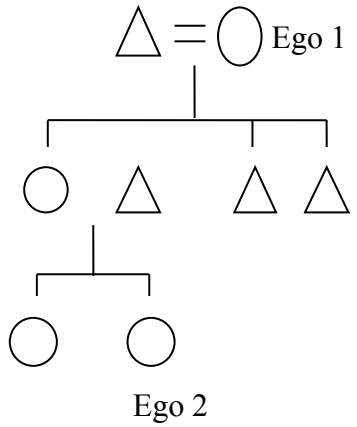

Figure 5: Kinship diagram for Nozamile*'s (ego 1's) family in the PSJLM.

Another dismissal of the assumption of rape or molestation came from Nokholo*, ego 1 in the diagram below and a 49 year-old mother with a Senior Secondary education level, who was the contact person at the PSJLM. She was fortunate enough to secure contracts with certain families requiring transport for their children to and from their respective schools. She had no additional income, but was managing well on what she earned as a school transport person. She is a highly religious person affiliated to one of the charismatic churches. She said that, as a convert to

Christianity, she no longer used traditional medicine, but shares the traditional belief in the existence of evil spirits and the role they play in the lives of human beings. Her husband was already deceased at the time of the interview, and she was raising three children and one granddaughter. Both Nokholo* and her daughter had experienced *ukuhanjwa* as an illness.

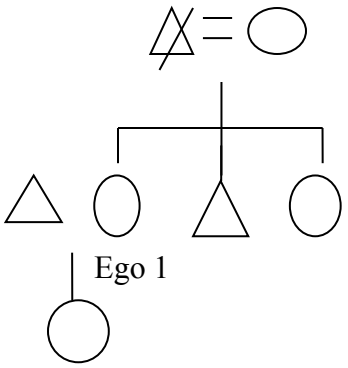

Figure 6: Kinship diagram for Nokholo*'s (ego 1's) family from the PSJLM.

Nokholo's first daughter (ego 2) experienced mild *ukuhanjwa*, with assistance coming from an elderly neighbour. Nokholo dismissed the idea that *ukuhanjwa*'s symptoms had anything to do with rape:

> *Lo mntwana uhleli naye ungunina okanye abe kumamazala xa uxakekile, umjongile ngamaxesha onke. Ulala naye okanye umgcinise kumamazala xa uxakekile ukwenye indawo. Akaphumi gazi kodwa ubomvu ngaphambili nangasemva futhi uvulekile. Xa umntwana ebambe ibele encanca, umlomo uwuva utshisa*.
>
> The child is always with you as a mother or with the mother-in-law when you are busy, looking after the baby at all times. You even sleep with the baby or leave the baby with the mother-in-law when you are busy somewhere else. The child is not bleeding but both

the anus and the genital opening would be red and wide open. When the baby is sucking milk from the breasts, the mouth would be burning with heat.

The illness is sometimes referred to as *isilonda* / *inxeba* (the 'wound') because of the ring of red patches which usually form around the anus. Siziwe*, a 36 year old mother from the HCBC as already explained above, highlighted that:

> *Akaqaqanjelwa phofu lo mntwana, kodwa uya kufika ebhontshiza. Esi silonda / inxeba sakhe silapha ngasemva siqala ngokuba sisitshitshilili samaqhakuva, ze ethubeni ahlangane abe sisilonda esivele sithi bhedu ngequbuliso ngethutyana nje elifutshane. Yiloo nto ke siye siqiniseke ukuba uhanjiwe ngoba sube engaqaqanjelwa futhi engophi nokopha nje ngoba kunokulindeleka kumntwana odlwengulweyo.*
>
> The child would not experience pain but would continue to be restless. The 'wound' around the anus would start by being a ring of pimples which would be later joined to form the 'wound', which would suddenly appear within a very short period. That is exactly the reason why we would be convinced that it is *ukuhanjwa*, because the child would not be experiencing pains and would also not be bleeding as would be expected with a child of rape.

Only one participant, Bongiwe*, a 46 year old mother from Mthatha in the KSDLM, mentioned the experience of pain and a 'wound' around the genitals of her sister's daughter. The majority of participants described a wound around the anus. She stated that the girl child screamed every time the wound was touched, indicating that the wound was painful. However, most of the participants did not associate a weary cry with pain but with tiredness – only a very loud and

specific cry was thought to be indicative of pain. Bongiwe* described symptoms which her sister could not associate with anything other than *ukuhanjwa*:

> *Yhoo! Okasisi umntwana waba nesitshitshilili samaqhakuva avele adibana asisilonda apha kwimilebe yobuntombi bakhe. Wayevele asitsho phezulu isikhalo qho xa ephathwa kweli nxeba. Wayeneminyaka emihlanu ukuhlaselwa kwakhe sesi sigulo. Umama wavele waqiniseka ukuba lo mntwana uhanjwe zizilwane zokuthakatha, zange abe ethandabuza ingakumbi xa umntwana engazange alufumane uncedo nakuwuphi ugqirha*.
>
> Yhoo! My sister's child had a ring of pimples which later joined and formed a wound around her genital opening. She screamed every time she was touched on the wound. She was five years-old when she was attacked by this illness. My mother became convinced without any doubt that this child had been spiritually penetrated by familiars, especially since the child could not get help from any doctor.

Bongiwe* herself is an employed graduate who believes that the illness exists, as the only explanation for the strange symptoms. Biomedical practitioners could not find a reasonable explanation and diagnosis for her niece's illness - hence they attached the name '*ukuhanjwa*' as the only explanation which made sense to them. The description by Bongiwe* is the same as that which was rendered by other participants except for the fact that in Bongiwe's niece's case the wound was on the genital and not the anus. Bongiwe* mentioned that the child was five years old, was not experiencing diarrhoea and had outgrown wearing nappies which disqualified the assumption of the biomedical practitioners that the wound could be as a result of long experience of diarrhoea and nappy rash.

The initial phase of the illness which indicates mild *ukuhanjwa* does not include diarrhoea, which disqualifies the suggestion by biomedical physicians that diarrhoea is a possible cause for the wide opening of the anus and the red patches around the anus and genitals. In addition, the phenomenon cannot be attributed to nappy rash. In rural areas, most children who have not yet been trained to use a toilet move about with their bottoms uncovered as a way of minimizing expenses. Nappy rash is fairly unheard of.

The Southern *Nguni* people's conceptual foundation of *ukuhanjwa* eliminates the biomedical assumptions of rape, molestation or nappy rash as possible aetiologies of *ukuhanjwa*. The names for the illness, and the social construction of the illness, are directly linked to the symptom as they present: as in *isilonda* / *inxeba* (the 'wound'), *ukudliwa* / *ukuhanjwa* (spiritual penetration) and *ukwebiwa* (stealing of the soul) which is linked to the laziness and sleepiness of the victim.

4.5. Aetiology of *ukuhanjwa*

The attributional theory as explained by Vaughn, Jacquez and Baker (2009, pp64-67) is relevant for contextualising the Southern *Nguni* conceptualisation of the spiritual causation of *ukuhanjwa*. This illness is attributed to the behaviour of familiars acting on their own, without having been instructed by witches, and the victims, in this regard, are understood to be "blameless with less control over the condition" (Foster, 2009, p116). In the Western, scientifically-defined rationalistic framework, witchcraft might not be recognized as real, but within African communities, it is a reality for most people (Petrus and Bogopa, 2007, p.2). This points to Barker's (2003, pp47-51) previously mentioned statements regarding knowledge and truth. According to their understanding, both urban and rural African communities believe that

witchcraft exists as a viable and plausible cause for misfortune, illness and death, regardless of whether these things can be scientifically explained or not.

With *ukuhanjwa*, witches and the victims are not blamed, since it is believed that, although familiars are owned by the witches, they sometimes loiter around without being sent by the witches to harm the victims. This implies that familiars sometimes operate without the witch's own desire. This understanding is applicable to familiars commonly associated with men, such as a certain type of snake called *ichanti*, as well as familiars associated with women, such as a certain type of mouse called *impaka*, or a snake called *irhamba* (puff adder). According to the informants, *ichanti* is known to be invisible to people in its snake form, but takes the form of anything – a horse, water, or anything else. Hence the informants could not describe it, other than stating that it is a snake which helps the owner to accumulate wealth. The description of *impaka* indicated something between the *Graphiurus murinus* (woodland dormouse) which has a bushy tail, known to be endemic to South Africa and the *Elephantulus edwardii* (Cape elephant Sengi) which has a very long nose. I*mpaka* has both a bushy tail and a long nose, and therefore falls somewhere between the two descriptions.

In their descriptions, participants state that familiars harm their victim by penetrating the body through any bodily opening. Nobom*, who had baby of one and a half years, contributed by stating that:

> *Zizilwane zokuthakatha. Zizo ezingunobangela wesi sigulo ngokuthi zingene ngaphakathi zimdle umntwana kuwo nawuphi umngxuma ezizikhethele wona. Ngamanye amaxesha zithi zimvuthele ngomoya omdaka ngaphakathi kule mingxuma owenza ukuba umntwana*

avuleke ngasemva ngenxa yamandla alo moya umdaka. Ikakhuku zithanda iimpundu, ngaphambili, nofokotho, kude kuthi zona ezi zamadoda, ziyabulala ngoba zizo ezi zimndla efokothweni lutsho lutshone. Akakhawulezi ukubonakala xa edliwe ngasentla. Kaloku indawo yokuqala esijonga kuyo ziimpundu thina. Ukuba iimpundu azivulekanga, kuba nzima ukuba sikhawuleze sazi ukuba lurheqo.

It is the familiars. They are the cause of this illness by penetrating inside the child through any bodily opening of their choice. Sometimes, they blow the evil spirit into these bodily openings causing the child's anus to open wide because of the power of this evil spirit. Mostly they prefer the anus, genital part or even the fontanel of the victim, especially familiars owned by men, which cause death by attacking the child on the fontanel, making sink. It is not easily identifiable when the attack has been on the upper parts of the body. Our first point of check is the anus. If the anus is not wide open, it becomes difficult for us to quickly identify it as *ukuhanjwa*.

According to the Southern *Nguni* people of the ORTDM, men's familiars are believed to attack the fontanel and other upper parts of the body, causing severe *ukuhanjwa*, while women's familiars attack the anus, genitals other bodily openings of the victim such as the nose, mouth and ears, causing mild *ukuhanjwa*.

The attack is referred to as *ukuhanjwa*/*ukudliwa* because the familiar would penetrate the bodily openings of the victim resulting in *ukuhanjwa*. Sometimes the attack would be called *ukwebiwa* (stealing of the soul) because the victim would be lazy, sleepy and inactive as a result of coming into contact with the familiar. Other people would refer to it as *isilonda* because of the ring of

pimples which have joined to form the 'wound' around the anus of the victim. Hence it was mentioned earlier that the identifiable symptoms had a direct influence in naming the illness.

Nokuzola*, described the features of one of the familiars and mentioned some of the reasons why familiars might attack a victim, as believed by the Southern *Nguni* people of the ORTDM. The participant further explained that these familiars are also known to be opportunistic, attacking children when they asleep or suffering from some unrelated illness:

> *Yimpukwana encinci ekuthiwa yimpaka, inempumlo ende, umsila osisihlakahlela, nemilenze emifutshane. Le mpuku ayityi kwanto xa ithe yafika endlini ngoba sube izele lo msebenzi wokudla abantu okanye abantwana kuphela. Ifika imvuthele, ze imsebenze apha ngasemva nakweminye imingxuma ngomsila lo wayo atsho avuleke. Le mpuku ayityi kwanto apha endlini xa ifikile ngoba sube izele lo msebenzi wokudla abantu kuphela. Xa libalele, kuye kuthiwe izilwane zilambile, zihambe zikhangela umntu okanye umntwana ongaqinanga zize zimhlasele zimdle. Naxa umntwana sele egula nasesinye isigulo ngaphandle kokuba ehanjiwe, ezi zilwane ziyakwazi ukuthatha ithuba zimhlasele*.
>
> It is a small mouse known as *impaka*, with a long nose, a long bushy tail and short legs. This mouse would not eat anything when inside the hut because its only intention would be to penetrate the person or a child. It would start by blowing the evil spirit into the victim, before penetrating the anus and other bodily openings with its long bush tail causing the anus to be wide open. This mouse does not eat anything when in the house since its main purpose would be to harm the victim. When it is sunny and with very high temperature, it is said that the familiar is likely to be hungry, and would set out to attack and penetrate the unprotected victim. Even when a child has a different illness other than

ukuhanjwa, these familiars become opportunistic and easily attack the victim causing *ukuhanjwa* to be concealed.

According to the interviewees of the ORTDM, this opportunistic attack would often confuse people, misleading them into treating only what they think of as a simple and recognisable illness, leaving the *ukuhanjwa* untreated and sometimes resulting in the death of the victim.

One of the elderly mothers, Nobongile*, described her initial encounter with *ukuhanjwa* when her daughter was attacked with the illness at a time when she was visiting her polygamous grandfather's home, where he had five wives. Her description of what was said to her by one of her grandfather's wives emphasised the role of 'loitering' familiars, acting independently of witches:

> *Waguqa ngamadolo umfazi omdala katat'omkhulu endithe ntsho emehlweni ezama ukucacisa ukuba izilwane ezo azithunywanga ngabo bengabafazi bakatat'omkhulu, koko bezizihambela nje zaza zahlangana nomntwana lowo ngengozi. Wacacisa ngelithi "asimdli thina umntwana womnye umntu ingakumbi oyintombazana, sidla amakhwenkwe azelwe yindoda yethu kuphela. Nokuba ebeyinkwenkwe lo mntwana wakho, besingazumdla, ngoba sidla amakhwenkwe azelwe yindoda yethu kuphela. Yiloo nto indoda yethu inabantwana abangamantombazana kuphela".*
>
> The eldest wife of my grandfather knelt down, looking me straight in the eye, trying to explain that the familiars were not sent by them as the wives to my grandfather, but they were just loitering about and accidentally came into contact with my child. She explained that "we do not harm another person's child especially a girl child, but we only harm the

> boy children born of our husband. Even if your child was a boy, we were not going to harm him, because we only harm boy children born of our husband. Hence our husband only has girl children.

She went on to explain that local people, including her grandfather and his first wife's brother, believed that his first wife had been a witch. Her acts of witchcraft caused her husband to chase her out of their homestead back to her paternal home, which was occupied by her brother. When she died, her brother refused to bury her within the confines of their homestead and instead buried her on a hilltop far from their home, in the belief that by doing so, he was isolating her familiars hoping that they remain around her grave, away from their home. Hence the Southern *Nguni* people of ORTDM believe that the owner of the familiars should find a person to inherit them before he or she dies, otherwise they would be left lingering freely in the wilderness, continuing to harm innocent people.

Nobongile* further described how she enjoyed working in her garden all year round, and had one day came across the root of a plant which had the shape of a baby girl. When she took it to the diviner out of curiosity, she was informed that the root could be used to prepare medicine for women who have difficulty conceiving. The medicine prepared from this plant would cause the woman to conceive a baby girl. The diviner further informed her that there is also another root which has the shape of a baby boy and when prepared as medicine may cause a woman to conceive a baby boy. She believed the diviner, based on the belief of Southern *Nguni* people that diviners have a deep connection with the ancestors, who communicate to them the names and appearance of medicinal plants, and their locations, function, and methods of preparation for healing. It is possible that some traditional medicinal plants were discovered accidentally, with

their functions having been revealed to diviners through their dreams; this may be the case with the plants used to heal *ukuhanjwa*.

It is accounts such as Nobongile's which tend to convince people of the spiritual origins of most conditions, including *ukuhanjwa*. When Nobongile*'s daughter showed all the symptoms of the illness, her grandfather's wives knew which emergency traditional healing methods to use to successfully heal the baby without having to visit a biomedical health centre or even a diviner. Their ability to heal as well as their explanation of the causes were accepted as the body of knowledge.

Conceptualisation of the *ukuhanjwa* was neither class-related nor gender-related and there would often be considerable consensus between the youth and their mothers regarding the model for conceptualisation of *ukuhanjwa*. Baer *et. al* (2003, p331) and Campbell (1975, p99) supported the argument that most folk-illnesses would not be class-related and that understanding of these illnesses would cut across all ages and include the youth. This became evident mostly in the four focus group discussions which were held in the research area with different age categories as well as males and females.

One thing which cannot be overlooked is that the study revealed what has been discussed by Naidu and Ojong (2010, pp96-112); that women, including those in ORTDM, labour under what appear to be prescriptive mothering mandates. The essential role of women regarding child rearing became clear during interviews, when no man indicated having played much of a role in taking care of children and none had identified the illness in a child, nor had taken direct action

to heal a child. This was an indication of the social construction of child rearing as "part of the world of women" as was posited by Tarlow (1996, p56) in Naidu and Ojong (2010, pp96-112). It became clear that most men, except the traditional healers, related only those stories which they had heard from their wives, sisters and mothers regarding ukuhanjwa. No man narrated how the illness may have inflicted another adult male, or how they may have been responsible for healing a fellow male attacked by the illness. Only female participants related their personal experience of the illness, either their own or that of their children. Female and male participants merely mentioned in passing that adult males were also vulnerable to attacks of *ukuhanjwa.* No participant wanted to dwell on the subject when it came to adult males as victims.

It may be that adult males did not want to appear weak by admitting to such a condition, with the anus and genital parts regarded as highly private. The admission of having allowed another person to view and touch adult male private parts could easily be too much of an admission of weakness and loss of power and control as a man – and no man was willing to risk being seen in that way. Another possibility could be that adult male participants may have responded differently if the researcher had been male, as indicated by Padfield and Procter (1996) in Naidu and Ojong (2010, pp96-112), where they state that common gender garnered more detailed answers from research participants. Common gender may well have payed a role in eliciting such intimate details from the female participants to this researcher, who is female.

4.6. Summary of the chapter

The conceptualisation of an illness by an individual or a society depends on the body of knowledge of the majority of those by whom one is surrounded. Hence it would not be surprising

to find a young person who has been brought up in a Western, modern society having a different worldview and approach to *ukuhanjwa* from an older traditional person. The Western-influened younger person may attach a different name to the illness and use a different healing method. The model for conceptualisation and social construction of *ukuhanjwa* among the southern *Nguni* people of ORTDM shows that despite the influences of Western values, there is sufficient traditional influence to motivate younger people to refer to their elders when dealing with *ukuhanjwa*. Their conceptualisation is based on the worldview of their elderly people as well as the environment which constantly surrounded them as they were growing up.

The belief is that *ukuhanjwa* is caused by penetration by familiars into the bodily openings of the victim, leaving the characteristic wide-open anus. Neither the witch nor the victim is blamed, as it seen as an example of "unintended pollution". The common understanding by the Southern *Nguni* people was that there is no way of preventing *ukuhanjwa* as the attack cannot be predicted, and that the only treatment is to act swiftly once the condition is recognised. Thus it is an illness to which one has to react, rather than pre-empt, since pre-emption, or protection, is only used when the presence of an evil spirit is suspected. This might be the case where someone is known to have an enemy in the community, and where the enemy is known to have access to spiritual forces of evil. In such a case traditional medicine might be used for general protection.

Overcoming fear of illness and death, demonstrating respect for and trust in elderly people and avoiding blame for illness and death are the most immediate and urgent obligations for caregivers of victims of *ukuhanjwa*. The impression is that the Southern *Nguni* people acquired satisfaction in the use of their preferred traditional methods of healing both solely and

concurrently with the biomedical healing methods but that they could not bring themselves to rely only on biomedical healing methods when it comes to *ukuhanjwa*. Out of 50 participants interviewed as individuals, only 2 (4%) confirmed that they believed in biomedical healing and prayer and would eschew the use of traditional indigenous methods for curing this illness.

The conceptual framework for this illness excluded the biomedical assumptions of diarrhoea or rape as explanations for the illness. So far, there has been no scientific procedure to prove whether '*abantu*' illnesses such as *ukuhanjwa*, witchcraft and other forms of supernatural activities are authentic or imaginary. Societies which believe that there is truth in the existence of witchcraft and other forms of supernatural activities have their own means of dealing with them, and have not found any need or means to authenticate their claims to the scientific evidence-based biomedical health system.

Out of the four forms of anal and rectal disorders that have been recorded, that is, proctitis, anorectal fistula, anorectal abscess and rectal prolapse, none has a description similar to that offered by the Southern *Nguni* people of ORTDM for *ukuhanjwa*. This could be another anal and rectal disorder which has not been identified by the biomedical health system. Misunderstanding regarding the illness persists in the biomedical community because of a) the delay in bringing the condition to the attention of biomedical practitioners, so that doctors remain unfamiliar with the illness in all its stages b) lack of explanation by mothers and caregivers regarding their observations, since caregivers assume that doctors can deduce everything for themselves.

Irhamba (puff adder) and *impaka* (a mouse somewhat inbetween the woodland dormouse, *Graphiurus murinus* and the Cape Eephant Sengi, *Elephantulus edwardii*), are believed to be familiars used by female witches, while *ichanti* (snake familiar) is the familiar believed to be used by male witches. These are the familiars known and believed to cause *ukuhanjwa*. The belief is that they act independently without the witch's volition. Hence their act does not affect social equilibrium and instead causes people to join together in their efforts to heal the ill as their priority.

Worldviews dominate when it comes to the interpretation of this and other *'abantu'* diseases. Lack of trust, and the conviction that biomedical practitioners are simply ill-equipped to deal with spiritual matters, keeps *ukuhanjwa* in the realm of diviners and home remedies. A detailed discussion on the concept of 'medical invisibility' will be rendered in chapter 6.

It became apparent that women had no difficulty in relating their experiences of *ukuhanjwa* in themselves or their children, whereas men distanced themselves regarding child rearing as well as this particular illness, possibly as a way of preserving the aura of male prestige and invulnerability.

CHAPTER 5: THE RELIGIO-CULTURAL FRAMEWORK INFORMING HEALING METHODS FOR *UKUHANJWA*

5.1. Overview

This chapter deals with the implications of illness and disease for the individual and society at large and outlines both the context of healing, as understood by the Southern *Nguni*, and the methods employed in healing. The term ethnomedicine includes every type of healing practice, including the biomedical, as the understanding is that they are all culturally informed, when the term is based on the cultural theory of modernities. Certainly, experiences of illness have always been interpreted according to cultural groups' contextual meanings. Different cultural interpretations have led to the development of cultural norms and social institutions concerned with health and well-being that vary from society to society. The history and discovery of traditional medicine for *ukuhanjwa* is particularly relevant as it has its roots in the beliefs, cosmology and perceived sources of power as understood by the Southern *Nguni* people.

This chapter also examines how the various forms of *ukuhanjwa* with their different symptoms inform which healing methods are used. Various healing methods are examined as is the argument for the continued use of these methods.

As has already been shown in Chapter 4, traditional (indigenous and indigenised) healing methods are almost always preferred for *ukuhanjwa* as it is perceived as one of several '*abantu*' illnesses which are 'medically invisible' to the Western mind and cannot therefore be cured according to the biomedical health system. In some cases biomedical health centres may well be consulted, but their advice regarded with some scepticism and used only alongside, rather than

instead of, traditional healing methods. This is an example of a pluralistic tendency in healing, where the biomedical approach may be thought of as having some efficacy with the physical symptoms, while the traditional approach is relied upon to address the spiritual or root causes of the illness.

The chapter also elaborates on the perceived sources of the healing power in these traditional healing methods. This encompasses the person who recommended the method of healing, the actual methods of preparing the traditional medicines, and how the healing methods were revealed to the healer. How these traditional healing methods are believed to work, and their relative efficacy, is also discussed.

5.2. Cultural norms and institutions linked to the well-being of a society

According to African tradition, the kraal or the cattle byre, the fire place, mountains, sea, rivers and sky are believed to be places where the supernatural powers of God and the ancestors reside – hence the respect attached to these places. Even their by-products are regarded as having the same power and healing effect as the places themselves. Everything linked to the kraal or cattle byre is believed to have the power to heal and to ward off misfortune (Ngqila, 2002, pp81-128 and Van Warmelo, 1988 in Ngqila, 2002, p9) – cattle, sheep, goats, the cow dung, and the space of the cattle byre itself. Cattle, sheep and goats are slaughtered during rituals as a sacrifice to connect to the ancestors for healing; the cow dung is used for surfacing the floor of the hut and to heal the remnants of the umbilical cord, which invokes the ancestors to protect the new-born baby, as mentioned in Ngqila (2002, pp81-128) and Naidu and Ngqila (2013, pp55-70). Many rituals are performed inside the kraal/cattle byre as it is a place of tremendous significance. For

this reason, women - who are often suspected of being "polluted" with menstruation or witchcraft - are not allowed to enter the cattle byre during times of rituals, as a mark of respect for the ritual and the ancestors.

Almost all cultural groups believe in the existence of a supernatural being above all of creation, with cultural norms, institutions, behaviours, interactions and taboos all based on the cosmology and worldview of the culture concerned. Those who believe in the existence of ancestors claim that they do believe in God. God is known as Q*amata* according to *amaXhosa* – the *Xhosa* people, *Umvelingqangi* according to *amaZulu* – the *Zulu* people and *Modimo* according to *abeSuthu* - the *Sotho.* Various other names are given to the same God depending on the cultural group concerned. According to the Southern *Nguni* people, ancestors are believed to be subject to the authority of God and sometimes used as his messengers. They play a particular role in directing diviners to where they can locate traditional plants for healing, and they also communicate with ordinary people through their dreams.

Most traditional people practice a form of communalism – hence one would find them performing rituals for rites of passage, harvest, rain, voyages and others significant events, for the benefit of the whole community. These rituals are mostly performed in open spaces, such as mountains when praying for rain and good harvest, the land in front of the homestead when conducting certain family rituals and rivers during the initiation of boys.

As in most cultures, the marriage relationship is experienced as an important locus of enculturation and a marker of the wellness of a community. Careful attention is therefore paid

when forming marriage bonds, in both the selection of a partner and in the rituals performed to mark the union. This is not only for the happiness of the couple but for the benefit of the extended family and whole community. Various rituals and taboos are observed throughout the marriage, which control the manner in which the marriage and family operate and which are believed to prevent misfortunes and ill-health. Endogamous marriages for example are a taboo especially in relation to lineages and clans, to prevent offspring with disabilities.

The main significance of communal religion is that it acts to maintain social control and cohesion for the better functioning and well-being of a society. Emphasis is placed on the stability and harmony of the whole, rather than of the individual; yet individual needs are not subsumed, rather they are assumed to find their fulfilment in communal happiness and harmony. If the community is well, so the individual will be well, the belief goes. Communality, with its rituals and taboos, enables traditional healing methods for illnesses such as *ukuhanjwa* to remain consistent through decades of change.

In matters of health, therefore, it becomes impossible to separate any one aspect of communal belief which impacts more than another on health and healing. Ancestors are essential – they are believed to be messengers of God guiding diviners on where to find medicinal plants and which methods to use for healing. The cattle byre is essential – it is the place where the ancestors are believed to reside. As is the hut, the mountains, the rivers and sky. Cattle, sheep and goats play a vital role by being sacrificed to ancestors so that they maintain their blessing over the home, keep guiding the diviners and continue to protect their living relatives from misfortune. Rivers and other bodies of water such as the sea are essential, as diviners, so essential to communal

health, are often initiated in bodies of water. Over all is the sky, where God resides, God who provides the plants for healing and who uses the ancestors as his messengers. And various rituals and taboos help keep all of these role players in communal health happy and correctly acknowledged. One cannot mention one without acknowledging the role of the other.

5.3. Implications of illness and disease

Illness can be viewed from the perspective of functionality and social control, by which is meant a society's ability to monitor and maintain balance and equilibrium in its functioning. Regarding this functionalism, Lupton, (2012, pp3-4) identifies deviation as a factor which affects the expected routine of a particular society, with expectations differing from society to society. The standard expectation in most societies is that its members will be healthy and functioning, and will be able to perform everyday activities adequately. Another standard expectation is that the rules and norms of the society will be adhered to by its members for social cohesion. Deviation from the expectations of the society may be in the form of breaking the rules or falling prey to ill-health (Lupton, 2012, pp3-4), both of which affect equilibrium and balance in the functioning of the society. In the case of the southern *Nguni*, breaking the rules or norms of society may also anger the ancestors, causing them to withdraw their protection over many generations of the family of the perpetrator, leaving them vulnerable to illnesses and other misfortunes.

Ill-health is thus viewed as a potential state of social deviation. Illness may result in an inability to conform to social expectations and norms and in addition, the illness may be perceived as an indication of the ancestors' displeasure. Illness is thus an unnatural state, causing both physical and social dysfunction. The ill person suffers a sense of vulnerability, having to rely on the help

of others to perform everyday activities, which places a burden on others. The ill person's contribution to the economic well-being of the family and the group may be seriously affected by illness the same way the caregiver who would be required to sacrifice time that might otherwise have been spent in earning an income. Hence illness is viewed as a deviation from the family and society's expectations, and a disturbance of equilibrium.

The ultimate goal of a society is to maintain social order amongst its members. Healing is one way to restore this social order once it is disrupted through illness. The physical disability of an individual is treated as an urgent call for attention which needs to be addressed as soon as possible, using medicine or whichever healing method is preferred for a speedy recovery and a restoration of balance and equilibrium both for the individual and society. The Southern *Nguni* people view ill-health as a result of *ukuhanjwa*, whether for a child or an adult person, as a matter of urgency, needing immediate attention and healing with minimal delay – hence the instantaneous application of traditional healing methods for quick relief.

5.4. Healing as a cultural practice

This section explores reasons why various healing practices, including biomedical healing practices, are viewed as cultural. It examines the manner in which illness impacts on social cohesion and explores various interpretations of illness that are put forward by specific cultural groups.

5.4.1. Impact of illness on social cohesion

It is important to bear in mind that all African traditional healing is completely intertwined with cultural and religious beliefs, rendering it holistic in nature. Healing encompasses not only the physical, but also the psychological, spiritual and social aspects of the person (Truter, 2007, p56). The spiritual aspect is always present in that God is seen as the ultimate source of healing herbs, creating them and allowing their uses to be revealed to man. The herbs used to heal *ukuhanjwa* are particularly bitter and unpleasant in taste and smell. Most of the participants in this study ascribed the power of the plants to heal *ukuhanjwa* to their bitterness, biting taste and strong smell. The very strong smell of the plants is believed to chase the familiars away from the victim. These familiars are perceived as the "efficient cause" (Hart, 1978, p74) of the illness in question and the actors responsible for the affliction. There is a perceived need to chase away familiars during the period of illness in order to allow the victim to heal without further spiritual interference. It is the spiritual penetration of the familiar into the body of the victim which is the "instrumental cause" (Hart, 1978, p74) of the illness. Regarding the "ultimate cause" (Hart, 1978, p74) or 'the person who caused' *ukuhanjwa*, the Southern *Nguni* people insist that they do not blame witches, even though the familiars may belong to them, as the familiars are in this case acting without the witch's volition – hence the illness has always been seen as "unintended pollution." Foster (2009, p114) is in agreement with this understanding of *ukuhanjwa*.

The question could be asked how the Southern *Nguni* people came to conclusion that *ukuhanjwa* was caused by familiars acting on their own without being sent by witches, since so many misfortunes are seen as caused by others, using supernatural agencies. The reason seems to be that in all these other cases, some quarrel or perceived state of jealousy exists between the victim

and the person accused of witchcraft. In the case of *ukuhanjwa*, these conditions are so often felt to be missing. Thus it becomes easy to ascribe the illness to the same supernatural beings but without the originating cause of some jealous or angry person.

In this respect, therefore, *ukuhanjwa* does not seem to be accompanied by a disturbance in the equilibrium or balance of social relations amongst family members and within the community in which it occurs. No blame is apportioned, and the focus for this illness seems to be quite uniquely on its cure, rather than on uncovering who caused it, as is the case with many other illnesses and misfortunes

The physical aspect of the healing method of *ukuhanjwa* draws in both the biomedical and the traditional healing systems, in that the Southern *Nguni* people of ORTDM would sometimes refer advanced cases of *ukuhanjwa* to biomedical centres. In these cases, though the caregiver might know the symptoms in detail, she would usually not point these out to the biomedical practitioners. Their belief would be that the biomedical health system should be in a position to diagnose the illness in its totality, identifying symptoms, nature and cure for the illness with no input from the family member concerned. This has always been the practice when Southern *Nguni* people visit diviners. Due to this misunderstanding, the diagnosis is invariably disappointing and has resulted in the common assumption that the illness is invisible when using the biomedical means of diagnosis. More discussion on the invisibility of *ukuhanjwa* with biomedical means of diagnosis is rendered in chapter 6.

The Southern *Nguni* people of ORTDM acknowledge the physical characteristics of the plants used to cure *ukuhanjwa*, combining this in their understanding with the conviction that spiritual power from God also contributes to the healing of the person. Their reliance on the physical properties of the plant can be seen in their conviction that the plant must be bitter and strong in order to work. It is the biting, bitter aspects of the plant which hold the power to shrink the bodily openings of the victim back to their normal size. The pungent smell has the spiritual power to repel familiars from the victim until healing has been achieved successfully.

To some extent, *ukuhanjwa* does disturb social solidarity in that it disturbs the equilibrium and balance of the victim and his or her family, both physically and spiritually. The belief held by the Southern *Nguni* people of ORTDM is that spiritual penetration of the familiars into the victim results in the victim being 'hot'. The immediate need is thus for the healing process to involve "cooling". Smith-Oka (2012, p11) mentioned the 'hot-cold' and 'wet-dry' concepts as being used by the Mesoamericans when referring to spiritual illnesses, something which is in agreement with how the Southern *Nguni* define illness and healing in relation to *ukuhanjwa*. The Southern *Nguni* people maintain that when a child or an adult person has *ukuhanjwa*, the victim's body becomes 'hot' requiring the use of a 'cool' healing method. Thus the focus within the Southern *Nguni* people when dealing with *ukuhanjwa* has always been with the individual who is a victim rather than with the whole societal group. This is in line with Malinowski's functionalist approach, as has already been demonstrated in the conceptual framework in chapter 4. The dominant concept of internal heat and coolness in *ukuhanjwa* is closely intertwined with the strong reliance on traditional herbs, which are seen as the only agencies by which heat may be "released." NoLungisile* noted that:

Umguli akacinyelwa ukuba makahambise koko ucinyelwa ukuba iyeza lihlale apha ngaphakathi kuye limsebenze likhuphe ukungcola kunye nobushushu.

The ill person would not be given the medicine for purging but for it to remain inside, for cleansing the dirt from the inside to the outside in order to 'cool' the ill.

More explanation on the healing methods of *ukuhanjwa* and how they work is discussed later in the chapter.

5.4.2. Meanings attached to traditional healing methods in relation to cultural illnesses

There are various types of '*abantu*' illnesses. Some manifest psychologically or in what appears to be "spiritual possession". An example is *amafufunyana* (spiritual possession). The Southern *Nguni* people explained *amafufunyana* as the condition in which a person's body becomes occupied by evil spirits. A woman may develop a strange, deep voice as if a man is talking through her, and a man may experience a female voice talking through him. One interviewee told of an incident which happened at a place called Norwood in Mthatha, in which a woman suffering from *amafufunyana* developed so much power such that she walked across the Mthatha River on top of the water, while people trying to catch her were still looking for a safe place to cross. By the time people managed to cross the river, she had disappeared into the bush. The interviewee had no idea whether the ill woman was ever found, as she did know the woman personally but merely witnessed the event from the river bank. The participant continued to explain that in a state of possession known as *amafufunyana*, the ill person would continually cry out in an attempt to run away at a high speed – hence it has always been difficult for people to catch a person with *amafufunyana*. The Southern *Nguni* people had no explanation for this kind of illness other than attaching a name of *amafufunyana* and categorising it under '*abantu*' or

cultural illness. In the case of alcoholics with hallucinations, the Southern *Nguni* people interviewed could not understand the hallucinations and conclude that this too is the work of the witches trying to steal the souls of drinkers by using alcohol as a disguise.

These explanations indicate that, like every cultural group, the Southern *Nguni* people struggle to explain many illnesses, and come up with an explanation that is in line with their worldview. The aetiology and cures which satisfy them will necessarily vary from those of other cultural groups. It is important to accept that the point of this discussion is not which system of healing is closest to the truth but to establish points of divergence and convergence in the different conceptual frameworks for illnesses. It is an attempt to bridge the gap between the different worldviews and to create better understanding of '*abantu'* illnesses in an era of globalisation, where the experiences of groups such as the Southern *Nguni* can no longer remain completely isolated.

Traditionally, African religion and healing work together with faith and belief, but material objects play a big role in enhancing and speeding up the process of healing. An example can be seen in the practices of a well-known faith healer who used to practise at Mhlontlo Local Municipality (MLM) in the OR Tambo District Municipality (ORTDM). During the research process, the name of this healer cropped up on many occasions. She was reputed to be able to heal people of all sorts of '*abantu'* illnesses, including *isigulo sengqondo* (mental illness), *uxhuzulo* (convulsions), *amafufunyana* (evil spirits living within the person), and alcoholic hallucinations. Strangely however, no participants ever mentioned her having cured someone of *ukuhanjwa*. This may be because in most cases the illness is dealt with at home.

When this faith healer started out, her reliance was seen to be totally on God. After she died, her followers continued her work by establishing a centre where the afflicted could come for prayer and healing. They began making use of material items to aid them in their healing. For example, a certain porridge, still prepared and sold at the centre today, is thought to contain much healing power. This porridge is a "relic" of the porridge which the founder cooked for her followers simply to sustain them physically as they awaited her healing touch. Her followers who now run the centre needed to sell the porridge for profit so that they would have funds to maintain the centre and themselves. They announced that whoever drank the porridge would be healed and people believed them as it is a cultural practice amongst the Southern *Nguni* people to believe in the use of material things for the purpose of healing. The porridge was no longer ordinary in the minds of the Southern *Nguni* people but was turned into spiritual porridge for healing purposes.

Another material object introduced by her followers as an aid to healing was a photograph of the faith healer, copies of which were sold to people who visited the place of healing. People were told that the photograph had protective power and should be displayed in their homes and cars to ward off any form of affliction or accident. Moreover, when a person was too ill to travel to the place of healing, items of clothing or any object belonging to the sick person would be brought to be prayed for. These would then be taken back home, together with some of the "miraculous" porridge for the sick person to drink. The belief is that the sick are healed as soon as the clothing is prayed for and as soon as they drink the spiritual porridge. Should the healing not take place, they would be blamed for not believing that the healing power in the items would work for them. In this regard, the real source of the healing power thought to reside in the material items such as the clothes, porridge and photograph may be said to be the faith of the believer. The person

believes that spiritual power is transferred from the faith healer's followers or from her place or from God, to their clothing, and from their clothing to themselves. This is what can be referred to as a culture of material and non-material healing.

The material culture of healing involves the use of symbolism, material objects, and rituals and blends easily with the non-material culture of healing. In this centre of healing, symbolism is present where clothing items are used to "symbolise" the ill person who cannot be present. The clothing items, the photograph of the faith healer and the porridge symbolise the deceased faith healer, her place of healing and her spiritual power. Porridge became imbued with this deep spiritual meaning because the faith healer had made the cooking of porridge a habit, and her followers took it a step further by imbuing the habit with spiritual power.

The same applies to the clothing items and the photograph of the faith healer. The clothing items symbolise the ill person who could not be present; by praying for the clothing, the sense is gained that the believer is in fact praying for the person. The photograph of the deceased faith healer symbolises the healer herself so that even those who have never seen her would have an idea of how she looked, and be able to relate to her and feel her presence in their home or car and in this way gain a sense of miraculous protection.

As faith in these material objects grew, it became customary for people to feel that even by being involved in the cooking of the porridge, they were advancing their own healing. Where clothing could not be brought, various other objects would be use to symbolise the sick person and various procedures followed to transfer healing power to these objects.

Similarly, in the treatment of *ukuhanjwa*, there is a clear belief in both material and non-material avenues of healing. Non-material avenues of healing would be the spiritual purification by and 'sympathetic magical' work of the traditional medicines in healing the harmed bodily parts of the *ukuhanjwa* victim. Spiritual purification has the same connotation as ritual purification, in which traditional medicine is believed to work spiritually to ward off familiars from spiritually penetrating the victim until proper healing has been achieved. Repelling familiars would be possible as a result of the very strong smell of the traditional medicines, as it is believed that they hate the smell of the *ukuhanjwa* traditional medicines. Sympathetic magical work of the traditional medicine would also help in "squeezing out" spiritual pollution in the harmed body parts of the victim, bringing about spiritual healing and a sense of ritual purification.

In the case of severe *ukuhanjwa* which is deemed by the diviner to have been caused by a familiar belonging to a male witch, the cure is very specific and clearly non-material – or at any rate, it must be classified as non-material because no adult person has ever seen what takes place with this cure. Wherever *ukuhanjwa* is caused by a male's familiar (*ichanti*) the customary solution is for a male witch to come forward and volunteer to cure the victim. The healing takes place in secret, and for this reason it is here categorised under the non-material culture of healing.

Material avenues of healing for *ukuhanjwa* are the plants prepared in various ways and used to bring about a reduction of the body openings to their normal size. Even the urgency with which

the caregivers approach the matter of healing a victim of *ukuhanjwa* can be seen as an aspect of the material culture of healing.

5.5. History and discovery of traditional medicine for healing *ukuhanjwa*

Patil (2011, pp25-29) explains the doctrine of signature as a belief in the power and wisdom of God in making plants that are useful in solving health problems. The Southern *Nguni* people of ORTDM subscribe to the doctrine of signature as explained by Patil (2011, pp25-29). Participants such as NoLungisile* aged 47, and a mother of three children, expressed this doctrine of signature when she said:

> *Ngamandla kaThixo athe wawanika iyeza eli ngoku ebelidala nto leyo engumthombo wamandla okusebanza kweli yeza.*
>
> It is God who gave power to the medicinal plant when he was creating it, which then becomes the source of the healing power for medicine.

According to the Southern *Nguni* people, in this regard, ancestors are used by God as messengers to inform and guide diviners as to where to find useful medicinal plants and how to prepare them for healing. This can also be linked to Oken's (2005) understanding that people are guided by their spiritual framework when they adopt certain healing methods. The participants interviewed by this researcher shared a belief that it is God who sends the ancestors to reveal traditional medicines to the diviners. Nobongile*, a female respondent of 86 years of age from King *Sabatha Dalindyebo* Local Municipality, is the elderly person who described visiting her grandfather's five wives when her daughter became afflicted with *ukuhanjwa.* Her understanding of the history and discovery of traditional medicinal plants and healing methods was that:

Zizinyanya ezibonisa amagqirha amayeza esintu ngokuthunywa nguThixo, azizi ngobubi zona sube zihambisa umyalezo osuka kuThixo njengezithunywa zikaThixo.

It is the ancestors who act as God's messengers by revealing traditional medicine to the diviners. The ancestors do not serve evil spirits, but convey a message from God as messengers of God.

Their belief has always been that diviners receive knowledge on medicinal plants and healing methods directly from the ancestors. Diviners in turn transfer this knowledge to their assistants, commonly known as *amaphatha ngxowa* (those who assist the diviners by carrying their medicine bags). *Amaphatha ngxowa* in turn become what is commonly known as *amaxhwele* (herbalists), using the knowledge they have acquired from the diviners. Those who have consulted either the diviner or herbalist then transfer this knowledge to their close relatives or friends, and that is how one finds people saying they learned about medicinal plants and healing methods from their elders. NoLungisile*, in support of what has been noted by Nobongile*, mentioned the transfer of knowledge from the diviners to their assistants (*amaphatha ngxowa*). NoLungisile*'s child experienced mild *ukuhanjwa*. She acquired knowledge on how to heal *ukuhanjwa* from her mother-in-law. She further stated that traditional medicine would be revealed to diviners in their dreams and that is how many of the elders originally found their knowledge.

Onke amayeza anyanga izigulo ezenziwa yimimoya emdaka aqala ngokuvela emathongweni kumagqirha ze amagqirha alugqithisele olo lwazi kumaphatha ngxowa awo. Lunwenwa njalo ke ulwazi ngamayeza esintu.

> All traditional medicines for spiritually caused illnesses begin by appearing in the dreams of the diviners, so that the diviners would transfer that knowledge to their assistants. That is how knowledge on traditional medicine is spread.

People such as NoLungisile* did not have to consult with a diviner when her child became ill, but acquired the necessary knowledge from her elders as well as from a herbalist with whom she worked closely. Explanations given by the Southern *Nguni* people revealed that they do not separate the work of the ancestors and that of God, but see God as overseeing the work of the ancestors.

The Southern *Nguni* people also emphasized that they communicated with ancestors as mediators between the living and God whenever they were seeking guidance on their everyday activities, not only for traditional healing. One of the reasons they trusted their ancestors as reliable messengers of God was they were the people they knew, loved and had interacted with while they were still alive.

5.6. Healing methods used for *ukuhanjwa*

Southern *Nguni* people of ORTDM have a belief that traditional home remedies are the most effective treatment for mild *ukuhanjwa*. These traditional home remedies are used as an emergency measure since the belief is that an immediate response is essential to beat the illness. Their belief is that for mild *ukuhanjwa*, emergency traditional home remedies are sufficient, but for severe *ukuhanjwa* expert help is needed. Home remedies may be used as 'first-aid' for severe *ukuhanjwa* but it would be essential to consult a diviner for more advanced traditional healing methods. The only time the Southern *Nguni* people visit biomedical health centres is

toboost the victim's energy with a 'drip', since their belief is that biomedical medicine does not have the magical power to effectively heal *ukuhanjwa* as a spiritually-caused illness. Reference has been made to 'traditional' healing methods as encompassing both indigenous and indigenized healing methods. Mostly, the majority of the Southern *Nguni* people insisted on the use of indigenous healing methods in healing *ukuhanjwa*. Only those who had been converted to Christianity use indigenized healing methods.

Zamile*, 85 years of age, who was interviewed as *ixhwele* (herbalist) at Mhlontlo Local Municipality (MLM), stated:

> *Isilungu asisebenzi kwesi sigulo. Sisigulo sesintu esi, ngoko ke sifuna ukunyangwa ngesintu. Isilungu sinyanga inyama, kanti isintu silwa nomoya omdaka sisilande ezantsi isigulo. Isintu sisebenza nonobangela wesigulo.*
>
> The Western healing methods do not work in healing this illness. This is cultural illness - hence it needs traditional healing methods. The Western healing methods heal the physical body whereas traditional healing methods target even the evil spirits, extracting the illness from the deepest parts of the body. Traditional healing methods also work on the causes of the illness as well for holistic healing.

The use of indigenized medicine for *ukuhanjwa* could be linked to the cultural theory of modernities or the theory of multiple modernities which encompasses cultural modernity and acultural modernity as discussed by Taylor (2001, pp1-9) and Eisenstadt (2000, pp1-29). They asserted that it has always been assumed that acultural modernity is from a culture-neutral point of view and that there is no pure modernity, but the reality is that only cultural modernity exists, with people modernized without abandoning their culture. Their understanding is that even acultural modernity is influenced by the Western culture, which qualifies it as cultural

modernity. This has been found to be true with traditional practices by the Southern *Nguni* people of the ORTDM regarding the healing of *ukuhanjwa*. We see it in their habit of using indigenous and indigenized healing methods as well as in their cultural pluralism, that is, their use of traditional and biomedical health systems simultaneously. Gangadharan and Shankar (2007, pp181-184); Varga and Veale (1997, pp911-924); Foster and Vilendrer (2009, pp1-7) have had encounters with practices of a pluralistic nature within the African health system, where traditional and biomedical healing methods are combined. They have noted that pregnant women, mothers and caregivers adopt these pluralistic tendencies as a way to protect the unborn and the newly-born from spiritually-caused illnesses and death.

Globalization does not adequately explain the issue of the pluralistic nature of healing and medicine, as suggested by Gangadharan and Shankar (2007, pp181-184). Globalisation instead favours mono-cultural approaches of acultural modernity. Hence De Andrade (2011, pp352-354) suggested that even biomedical practitioners should try to "be traditional" in their interaction with their patients. By being traditional, De Andrade was referring to the approach applied by the traditional healers, in which respect for the patients' worldview becomes the point of reference for the healing practice. It is "patient-centred" rather than "doctor-centred". Traditionalism, in this context, could mean an attempt by biomedical practitioners to eliminate the "invisibility" of *ukuhanjwa* by specifically asking caregivers for their observations, and helping to draw them out from their customary silence in this regard. This could assist the biomedical practitioners to be more precise when examining the symptoms as described and understood by the Southern *Nguni* people when they do decide to bring their ill children to the biomedical health centres. More

visits to the biomedical health centres at the mild stage of *ukuhanjwa* could help eliminate the assumption that the open anus surrounded by red patches is caused by prolonged diarrhoea.

Currently there are limitations on the workability of this idea, as so few Southern *Nguni* people interviewed are interested in attending biomedical health centres for mild *ukuhanjwa*. Most interviewees who took mild *ukuhanjwa* cases to biomedical centres said that they did so only to pre-empt being scolded by the nurses for delaying, should they have to consult the biomedical centre when the illness becomes severe. Immediately after leaving the consultation room at the biomedical health centre, they would secretly apply their traditional medicine to the victim, even while still in the hospital grounds. In the case of severe *ukuhanjwa*, when many people who resort to visiting either a diviner or a biomedical health centre, all interviewees said they would apply their traditional remedies before leaving home.

Indigenous healing methods include all the healing methods which are regarded as indigenous to a particular cultural group without links to any foreign culture. In the case of the Southern *Nguni* of ORTDM, indigenous healing methods can be divided into three categories:

The first is a concoction made from crushing the plant(s) specific to the area or municipality where the victim lives and immersing it in half a cup of cold or warm water. Warm water is mostly used for babies to minimize chances of catching cold. The second is a concoction made from plants found across the five different local municipalities of ORTDM. The third is a decoction, or paste, made from boiling the familiar which is deemed to have caused the trouble; the *impaka* or *irhamba* owned by women, and then drunk in small quantities. Where the illness is

deemed to have been caused by a male familiar – *ichanti* – the remedy is known only to the owner of *ichanti*. In such cases the victim is taken to the owner, and he is asked to heal the victim, or the perceived witch himself may come forward to volunteer to heal the person. The concoction for mild *ukuhanjwa* is used as both a drink and to apply topically, whereas the decoction for severe *ukuhanjwa* is used as a drink only. The actual plants used in the different five municipalities are: the roots of *isivumbampunzi* for KSDLM, the leaves of *ityolo* and *umsuzwana* for PSJLM, the leaves of *ubutshwa* for MLM, the leaves and stem of *umhlonyane womlambo*, *umabophane*, *umboziso* and *umpondlampondla* mixed together for IHLM, and the leaves of *ugangashane*, and *inzinziliba* for NLM.

There are also two plants found in all five areas and used by all: *isivumbampunzi* (*Tulbaghia violacea*), and *iboza* (*Plectranthus barbatus*).

What all these plants have in common is an exceptionally bitter and biting taste and a strong smell. These work in two ways; the taste and smell are believed to repel the familiars, and they also act according to a process known as "sympathetic magic" (Leclerc-Madlala, 2002, pp 92-93). Sympathetic magic in this case refers to the idea, subscribed to by the Southern *Nguni* people, that since the muscles of the face contract when a person tastes these plants, the plants must have the same effect on the rest of the body, forcing it to contract and thus shrinking the wide open anus back to its normal size.

The decoction made from boiling the familiars is used only for severe *ukuhanjwa* and is prescribed only by a diviner. He or she would do so after a thorough examination of the victim, after which he or she would inform the caregiver or victim which type of familiar was

responsible. The decoction for severe *ukujanjwa* is taken orally while simultaneously applying the concoction for mild *ukuhanjwa* to various body parts. It is used only in cases where the familiar is thought to belong to a woman; as mentioned earlier, where the familiar is thought to belong to a man, the owner himself is required for healing to take place.

The medicines made from the plants are known to be very strong and it is recommended that only one teaspoon should be given to babies for a drink, especially in the case of *iboza* (*Plectranthus barbatus*) and *isivumbampunzi* (*Tulbaghia violacea*). Similarly, with the decoction made from the familiar, a very small quantity is drunk. In the case of both mild and severe *ukuhanjw*a, a small measure of the decoction, enough to heal but not sufficient to constitute an enema, is applied into the anus, and few drops into all other bodily openings, including the genitals. The Southern *Nguni* people are very cautious and precise about measurements, especially for babies since the medicines are known to be strong, even for adults.

As was indicated earlier, *impaka* has a long nose and a bushy tail, leaving one wondering whether it would be possible to find such a creature in the OR Tambo District Municipality for use during preparation of the decoction for healing. The possibility is that there is a mouse of that description which has yet to be discovered by biologists. Possibly the Southern *Nguni* people use a description closest to their observations, and that in fact *impaka* is one of the mice already known to biologists.

Use of the decoction made from the familiars is believed to work the same way as the concoction of plants - through ‘sympathetic magic’. After the use of the decoction to heal the victim, the

odour of the familiar would remain in the body of the victim, repelling the familiar away during the time of the illness and preventing it from reattacking the victim until full recovery has been achieved. The odour of the familiar helps to confuse the familiar when it attempts to reattack the victim, as it would assume that the victim is another familiar and as a result would be repelled. Sympathetic magic is believed to play a major role for both the concoction and the decoction for successful healing to take place.

The Southern *Nguni* people guaranteed 100% success rate in healing mild *ukuhanjwa,* something which they could not guarantee for severe *ukuhanjwa*. The indication was that, in the case of severe *ukuhanjwa*, there was less than 50% chance of successful healing and a more than 50% chance of the death of the victim. Out of three participants who had children with severe *ukuhanjwa*, only one participant had a child who was successfully healed. Children of the other two participants died from the illness. One of the participants, Nozukisile* of Nodushe location in Nyandeni Local Municipality (NLM), who lost a child as a result of severe *ukuhanjwa*, indicated that:

> *Ndamthatha ndamsa eclinic akancedakala. Ndandingekalazi iyeza lenxeba ngelo xesha. Eclinic bamnika amanzi anetyiwa neswekile ngoba ude wabe uyagabha kule ngulo yakhe. Zange aphile ngoba sasesondele isigulo*. *Wasweleka xa ndisandula ukufika naye egqirheni lisaqala ukumnyanga.*
>
> I took my child to the clinic where she could not get help. I was not aware about any traditional medicine for the wound at that time. At the clinic they only gave her water with salt and sugar because she ended up vomiting as a result of her illness. She could not

be healed as she was at the severe stage of *ukuhanjwa*. The child died on our arrival at the diviner's place at the time when the diviner was beginning to heal her.

Illness causation was detected as *ukuhanjwa* by the diviner but it was too late for the diviner to be able to heal the victim. The implication is that even diviners cannot guarantee successful healing when the victim has reached the severe stage of *ukuhanjwa*. Hence the Southern *Nguni* people expressed their fear for the illness. This was another example of the pluralistic tendency, with the mother beginning with biomedical healing methods and later following with traditional healing methods, in her desperation to save the baby. She did not know whether traditional medicine was going to help save the child or not, as she was aware that the illness had advanced. She was 45 years old at the time of the interview. But she said that at the time of the illness she was still young and knew nothing about traditional medicine for *ukuhanjwa* - otherwise she would have started with the use of traditional medicine like the most of the Southern *Nguni* people interviewed. It was her first child and her first experience of encountering the illness. She first opted for the clinic instead of the hospital because the hospital was far from where she lived. Hence from the clinic she went straight to the traditional healer or diviner, as it was the nearest option for her urgent situation.

In addition to the indigenous healing methods, the Southern *Nguni* people interviewed also make use of indigenized healing methods. Chief amongst these seems to be *amafutha enja yolwandle*, commonly known as Genuine Seal Oil, sold at chemists. According to a dealer, Genuine Seal Oil is used as a moisturizer and taken orally for general health and well-being, as it is a source of Omega 3 fatty acids and good for cardiovascular health and lowering cholesterol. The Southern *Nguni* have indigenised this oil, using it in ways specific to their needs. For *ukuhanjwa*, a few

drops are applied into all bodily openings, and a few drops are drunk. It's strong odour, which is known to remain on the body for at least a day, is thought to repel familiars. This implies that *amafutha enja yolwandle* (Genuine Seal Oil) could be used as a potential pre-emptive measure in the same way *haarlemensies* is used. Many Southern *Nguni* people use *haarlemensies* to chase away evil spirits, but strangely, it was never mentioned as a cure or a pre-emptive measure specifically for *ukuhanjwa* in any of the areas visited by this researcher.

Haarlemensies, like Genuine Seal Oil, has been indigenised; its "official" use is treating minor kidney and bladder complaints, but the Southern *Nguni* people use it for chasing away evil spirits (Ngqila, 2011, p14). And yet nothing is used pre-emptively in the case of *ukuhanjwa*. The common understanding seems to be that there is no way of preventing familiars from attacking people; and yet there is some discrepancy here, since when a person suffers from *ukuhanjwa*, the caregiver will administer the prescribed concoction or Genuine Seal Oil both to heal and prevent the familiar from re-attacking. Thus some form of prevention is practised, but only immediately after an attack. All those interviewed said they discontinued use of the medicines after healing has been accomplished. Only one 71 year old participant, Nosebenzile* from the Nyandeni Local Municipality (NLM) of ORTDM, said that there is no evidence that *ukuhanjwa* cannot be prevented. This participant highlighted that the common practice by most Southern *Nguni* people is to use medicine religiously only when the patient is ill, but after healing no steps are taken to ensure continued good health – until there is another attack. This is the case for all illnesses, not only for *ukuhanjwa*.

Nosebenzile* is the only participant who used preventative measures over the long term for *ukuhanjw*a. She said that, after the death of her child from *ukuhanjwa*, she insisted on the application of *amafutha enja yolwandle* (Genuine Seal Oil) as her pre-emptive and protective measure for the whole body of all her children. She maintained this practice for years, paying special attention to the fontanel, since it is first target of the familiars belonging to men, which cause severe *ukuhanjwa*:

> *Ndaba nelishwa lokuva ngamafutha enja yolwandle emva kokuba sendibhujelwe ngumntwana wam wesibini ngenxa yesi sigulo. Ukusukela ngoko zange ndiphinde ndahlukane neli yeza. Bonke abantwana bam ndabahlalela ngokubathambisa ngeli yeza kangangokuba zange ndiphinde ndifelwe mntwana ngenxa yesi sigulo. Ababhubhayo basutywa yingozi okanye ingulo nje eqhelekileyo ngoku sebengamadoda amadala.*
>
> It was an unfortunate event that I only heard about *amafutha enja yolwandle* (genuine seal oil) after the death of my second child as a result of this illness. As from that time, I never stopped using the medicine. I constantly applied the medicine to all my children so that I never experienced any child death as a result of this illness. The two who died, the cause of their death was accidental from faction fights and natural death from ordinary illness.

She explained that she never strongly believed in using indigenous medicinal plants and when she was told about *amafutha enja yolwandle* (Genuine Seal Oil) as an indigenized medicine, it became her preferred traditional healing method for *ukuhanjwa*:

> *Ndiye ndisebenzise amafutha enja yaselwandle ngoba atsho kuqala kwesi sigulo. Ndiye ndiwaqabe apha efokothweni nasentanyeni, ze ndimphe amaqabaza amane asele,*

ndimqabe zonke iintunja zomzimba kude kuthi kona apha ngasemva kufuneka ube ngathi uyawufaka umnwe oneli yeza kuba ezobe evulekile.

I use Genuine Seal Oil because it targets the affliction. I apply the oil to the fontanel and the neck, administer four drops of the medicine for the child to drink and a thoroughly apply of the oil to the rest of the bodily openings, especially thrusting the finger with the oil into the anus.

She is not highly educated, with a primary level of education, and she attributed her belief in indigenized medicines to the influence of Christianity. This is unusual, since many interviewees who used traditional medicines were Christian believers too. She confined herself to the indigenised treatment, whereas others would use both the indigenous and the indigenised. Unlike her, too, none of the others – not even those who had experienced the death of a child due to the illness - used the medicine pre-emptively. The figure below illustrates Southern *Nguni* people's conceptual framework on traditional healing methods for *ukuhanjwa*:

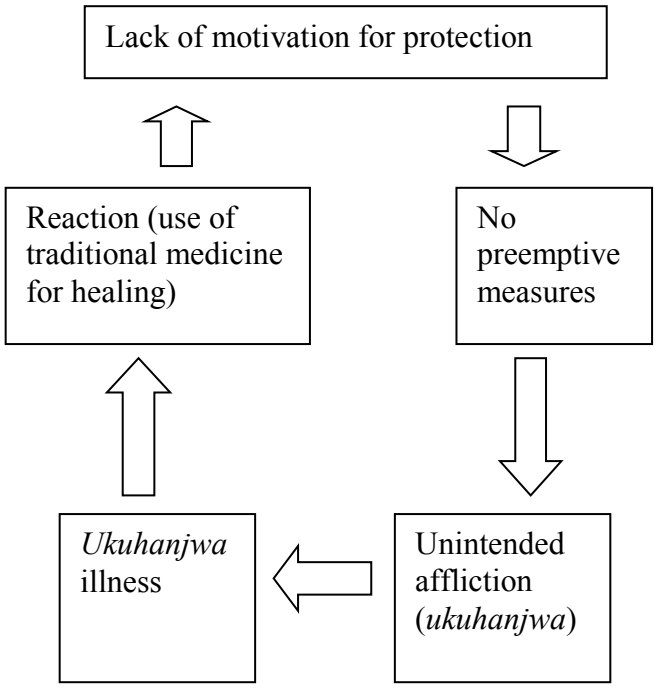

Figure 7: Healing framework - Reactive response of Southern *Nguni* people of ORTDM on *ukuhanjwa*, health and medicine.

The practice of not bothering with preventative measures is in alignment with the Southern *Ngunis*' worldview on the question of illness, health and medicine. The indication is that their common practice is to react instead of prevent. They use traditional medicine, indigenous and indigenized, for repelling evil spirit or preventing illness only when they become suspicious that something has gone wrong, or is about to. For example, they might use it pre-emptively where suspicions are aroused that there is evil about, such as when a witch is known to harbour enmity towards a family, or when for some other reason an evil spirit is suspected.

In the case of *ukuhanjwa*, the Southern *Nguni* people have always been caught off guard since according to their worldview, they do not associate *ukuhanjwa* with enmity and social discord – it is an unintended and, accordingly, unpredictable attack by a random familiar. This lack of interest in prevention could be similarly present in the current attitude towards HIV/AIDS which continues to infect vast numbers of people despite the available preventive measures – though it must be acknowledged that the circumstances surrounding these two conditions are quite different.

Regarding the preparation of *ukuhanjwa* remedies, the Southern *Nguni* people throughout the five local municipalities, used the same methods for mild *ukuhanjwa*, especially in the case of the commonly used plants such as *iboza* (*Plectranthus barbatus*) and *isivumbampunzi* (*Tulbaghia violacea*). *Iboza* (*Plectranthus barbatus*) is known to be a very strong medicinal plant, and the Southern *Nguni* people always caution each other never to exceed two leaves of it for half a cup of water when preparing the medicine for a child. With *isivumbampunzi* (*Tulbaghia violacea*), they are less precise about the numbers of leaves to half a cup of water though it, too, is strong. For both plants, the Southern *Nguni* people crush the leaves to extract the juice. The leaves are then immersed in half a cup of water, cold or lukewarm, to make a concoction, depending on whether the medicine is being prepared for a child or an adult – it is usually lukewarm for the child. The concoction is then drunk – a teaspoon only – and used to drop a few droplets into all bodily openings. NoLungisile*, like other participants, said that:

> *Kulo mxube umntwana umseza i-teaspoon kuphela ze emva koko umkhamele ngamaqabaza eli yeza kuyo yonke imingxuma ze eshiyekileyo umcime ngayo. Umcimo kufuneka umncinci ngoba akacinyelwa ukuba ahambise, koko kufuneka likhe lihlale*

lisebenze apha ngaphakathi ukuze xa liphuma likhuphe ubushushu nokungcola okwenziwe sisilwanyana eso.

From the concoction, a child should be given only a teaspoonful, and afterwards the remaining concoction should be used to apply small droplets to all bodily openings of the victim and as an enema. The enema has to be a small amount, not for purging the victim, but to allow it to cleanse his/her internal organs so that when releasing the bowels it comes out, together with the evil spirit and the heat, which resulted from the contact with the familiars, for the victim to cool.

This cooling effect in traditional medicine has also been mentioned by Smith-Oka (2012, p11) who refers to the concepts of 'hot-cold' and 'wet-dry' as used by the Mesoamericans in healing. U*kuhanjwa* is regarded as being 'hot', causing the victim to be 'hot' and in need of the 'cold' medicine to 'cool'. The contextual meaning 'cold-hot' does not refer literally to the temperature of the person or medicine, but rather to the "characteristics of their temporal nature" (Smith-Oka, 2012, p11).

Participants particularly from *Qokolweni* location of the KSDLM in the ORTDM, such as Zodwa*, a 45 year old woman, said that for them it is the roots of *isivumbampunzi* (*Tulbaghia violacea*) which they use for a drink and for dropping into all bodily openings. They use the crushed leaves for mixing with bath water to wash the body of the victim. Their belief is that juices of the roots are more concentrated than those of the leaves:

Kuthi ziingcambu zesivumbampunzi ezikhandwe zaxutywa namanzi ezibalulekileyo ekusezeni nasekukhameleni umntu ohlaselwe kukuhanjwa ze amagqabi akhandiweyo siwasebenzise ukuhlamba umzimba womguli.

With us the crushed roots of *isivumbampunzi* (*Tulbaghia violacea*) mixed with water are far more important for use as a drink and drops into the bodily openings of the *ukuhanjwa* victim, while we use crushed leaves for mixing with bath water for washing the body of the ill.

Many people, however, favour indigenised solutions, of which Genuine Seal Oil is one. Another favoured by those in urban areas and some (not all) converts to Christianity is toothpaste. Many Southern *Nguni* people believe that the colour 'white' signifies ritual purity and cleanness. In addition, toothpaste is usually menthol or mint flavoured, and thus gives the impression of being 'cooling'. A small amount of toothpaste – just the tip of a finger - is applied to the anus to 'cool' the victim. In contrast, some Southern *Nguni* people use black shoe polish in the same way and in the same quantity, also to "cool". These practices indicate that some aspects of the indigenous culture remain, even amongst those who have been urbanised or who have converted to Christianity; they have assumed the cultural modernity approach, as explained by Taylor (2001, pp1-9). Their cultural modernity entails the indigenization of products with a temporal shift from the products' original function to a spiritual function.

With severe *ukuhanjwa*, two solutions are used, depending on whether the diviner deems the familiar to belong to a female or to a male witch. Familiars belonging to women, that is *impaka* and *irhamba,* must be caught and boiled, as explained above, and the liquid drunk in minute

quantities. But in the case of *ichanti,* the male familiar*,* only the intervention of the owner can cure.

In most cases, the owner will get to hear of the illness and come forward to volunteer his help. Although he is not held responsible for the actions of his familiar, and even where he may not have owned that particular familiar, if he is known to use *ichanti*, only he can magically cure the victim. His volunteering to help would be seen as a gesture of kindness, proving his innocence. As a gesture of goodwill and to restore social relations, he would generally cure the victim. How he does this was not known by any of the participants in the study.

It is believed that owners of *ichanti*, who use this creature to amass wealth for themselves, are secretive about owning *ichanti*. They prefer to hide their magical means of accumulating wealth and to pretend to be respectable, wealthy community members who have acquired wealth in an acceptable manner. All owners of familiars, according to the Southern *Nguni* people, are aware of the involvement of their familiars in causing *ukuhanjwa,* but are unable to control them – hence they are pardoned by the community.

A group of participants in this study, who were biomedical nurses from Ntlaza location, *Nyandeni* Local Municipality (NLM), were aware of *ukuhanjwa* and indicated that the illness and its cure left them confused. They revealed that:

> *Abanye abazali baye bathi sebemzisile umntwana wale nto, athi kuba sele engasanyangeki, bacele ukuba bambolekwe besithi bamsa kumnikazi wesilwane ukuze*

amphathaphathe ngendlela zakhe atsho aphile kunjalo nje. Lo nto ke isitsho sixakeke ke nathi bezempilo singazi noba masikholelwe kubukho besi sigulo okanye hayi.

Some parents decide to ask permission to take their child to the owner of the familiar which has attacked him/her so that the owner of the familiar would have time with the victim to do his magic to heal him/her, and it does work most of the time. It is such incidents which leave us as biomedical health workers very confused whether to believe in the existence of this illness or not.

5.7. The source of healing power in traditional healing methods for *ukuhanjwa*

This section elaborates on how the source of healing power motivates Southern *Nguni* people to use traditional healing methods for *ukuhanjwa* rather than biomedicine. With *'abantu'* illnesses, the person who recommends the method of healing, and the manner in which the healing method is revealed to the recommending person are believed to be some of the sources of healing power for the illness.

Firstly, the healing power is believed to come from the plant itself. 90% of participants across the five local municipalities acknowledged that medicinal plants used for healing *ukuhanjwa* have spiritual healing power within the plants themselves, working through the plants' bitterness, biting taste and smell. These healing properties are understood to come from God. They do not come from the ancestors or the diviner. The ancestors merely guide the diviner where to find the relevant plant:

Kukukrakra, ukutsweba, nevumba lala mayeza ezingumthombo wamandla okusebenza kwala mayeza ngokunikwa nguThixo. Ukukrakra nokutsweba kuko okwenza ukuba

imingxuma yomzimba womguli ibuyele kwisimo esiqhelekileyo ze ivumba lona ligxothe isilwanyana eso ukuze singabuyeleli kwakhona de umguli aphile ngokupheleleyo.

It is the bitterness, the biting taste and the smell of these traditional medicinal plants which are the source of the healing power as created by God. It is the bitterness and the biting taste which heal the bodily openings of the ill back to their normal size and shape, whilst the smell is for chasing away the familiar so that it would not re-attack the ill until fully recovered.

Secondly, the healing power is believed to derive largely from the faith of the person using the plants. Nokholo* emphasized this role that faith or belief play in healing:

Yinkolo yomntu enika iyeza amandla ngokokwam ukuqonda. Nditsho mna nakwaba besiNgesi oogqirha ndiphila kugqirha endikholelwa kuye, hayi nakowuphi ugqirha, kungokunjalo ke naseyezeni lesiNgesi. Ngolu hlobo inkolo kwibhayibhile esebenza ngayo, ikwanjalo ke ukusebenza nenkolo kwisintu, futhi sitsho sisebenze simncede umntu okholelwa kuso.

It is the individual's belief and faith which becomes the source of the healing power according to my understanding. Even with the biomedical physicians, I get healed only by the one I believe in, not just by any other biomedical physician – the same applies even with biomedicine. The way belief and faith in the Bible works is the same way it works with belief and faith in traditional religion and traditional medicine, and they work for those who believe in them.

The ill person or caregiver has to have belief and faith in the traditional healing method as well as trust in the person (elder or diviner) who is recommending the healing method. This includes the diviner, the herbalist, the elder and even the neighbour recommending the healing method. It might even include the history of how the ill person or caregiver came to know the person recommending the healing method. Thus healing involves social bonds; it is strongest where trust is present. In this way we see again how the health of the individual and the "health" of the community are inextricably linked. Good social relations lay the foundation for successful healing of the individual.

The third source of the healing power for traditional Southern *Nguni* people is to do with the ritual space used for healing and for gathering the plants. Spaces are ritualised and circumscribed, and as such, cannot be tampered with. In the area of healing, the male owner of the *ichanti* snake has always insisted on being alone with the victim in his designated space. He would ask the caregiver or mother of the victim to remain outside his designated space in order for him to heal the victim successfully. This is the reason why the Southern *Nguni* people have no knowledge of how this particular healing – for severe *ukuhanjwa*, when caused by a male witch's familiar - takes place. The source of the healing power in this regard is in the isolation of the male witch and the victim from the caregiver, and their seclusion in the designated ritual healing space.

Another significant ritual space is that of the growing place for the traditional medicinal plants used for healing *ukuhanjwa*. The Southern *Nguni* people, especially those of Lotana location at Mhlontlo Local Municipality (MLM), insist on picking these medicinal plants from outside their

homesteads. Their belief is that those traditional medicinal plants within their homesteads may have been trampled on by the familiars when they were making their way to attack the victim, causing them to lose their healing power. They believe strongly that medicinal plants picked outside the premises retained their spiritual healing power, as they had not been polluted by the trampling of familiars. In this regard, the source of the healing power is the place where the plants are found. Traditional people would not trust plants picked close to the home. One of the participants, Nokwakha*, confirmed this assertion by stating that:

> *Iyeza lesintu lokuhanjwa kufuneka likhiwe ethafeni, lingakhiwa egadini okanye ngaphakathi ekhayeni lomguli kanti nakweliphi na ikhaya. Kaloku amagqwirha nezilwanyana zawo zokuthakatha ayahambahamba apha emizini yethu athomalalise amandla ala mayeza*.
>
> Traditional medicinal plants for *ukuhanjwa* have to be picked in the field, not in the home garden or within the premises of the victim's home or any other person's home. Apparently, witches and their familiars walk around within the premises of our homesteads causing the traditional medicinal plants to lose their healing power.

Lastly, the fourth source of the healing power is the ritual timing for healing the victim of *ukuhanjwa*. The Southern *Nguni* people are adamant that the healing response must be immediate, whether the illness is mild or severe. Failure to do so always leads to regression – from mild to severe *ukuhanjwa* and from severe *ukuhanjwa* to death. This leaves no time for considering the use of biomedical methods. Travelling to biomedical centres would take time, and the delay could cost the victim his or her life.

It would be interesting to know which indicators of the source of healing power keep the Southern *Nguni* loyal to traditional healing methods in this era of globalization, where great strides are made by the biomedical health system annually, to the point where all other healing methods the world over are dwarfed. One needs to remember that the Southern *Nguni* people learned about traditional healing methods from their diviners. Such is their respect for diviners that they have never enquired about the source of the healing power, other than by making their own deductions based on the taste and smell, and their own involuntary facial contractions when they are exposed to the plants. It is their own experience of tasting and smelling, coupled with positive results, that seem to have led them to conclude that it is the taste and smell, as the most outstanding characteristics of the plants, that produce the healing.

It also seems like a fairly logical leap to conclude that since the taste and smell cause muscular contraction in the face (the typical facial expression of revulsion), they would have a similar effect throughout the body and thus contract the open muscles of the anus. This is the process of "sympathetic magic". It is not the working of logic, but a recognition of the mysterious. Everything that works in ways mysterious to the user is assumed to belong to the realm of the spiritual, and the realm of the spiritual, where it works for good and not for evil, is assumed to be under God.

Another matter of interest are the factors which motivate the Southern *Nguni* people to trust the person recommending the healing method, and which factors enable them to differentiate between a person with genuine knowledge and someone whose knowledge is mostly fake. The Southern *Nguni* people indicate that they rely mostly on evidence-based testimonies from their

elders regarding methods of healing and who to trust to effect healing. When it comes to diviners, their track record of successful healing speaks volumes. Interestingly though, most Southern *Nguni* people prefer to opt for a diviner who lives very far from their own place of residence, trusting that he or she has no knowledge about the patient's circumstances. In this way, a diviner who is successful with healing proves that his or her knowledge was obtained through spiritual channels and not by being party to local gossip. This distance, coupled with a good track record, seem be the main indicators for loyalty to a particular diviner.

The significance of ritual space and ritual timing for traditional medicinal plants and traditional healing cannot be overemphasised. They have been revealed as the cornerstone and source of the healing power for successful healing of *ukuhanjwa* and thus cannot be taken for granted. Ritual timing becomes significant in minimising chances for the illness to escalate from mild to severe *ukuhanjwa* and from severe *ukuhanjwa* to death of the victim whilst ritual space helps in maintaining the strength and healing power of the traditional medicinal plants or traditional healing method.

5.8. Efficacy of the traditional healing methods in healing *ukuhanjwa*

The Southern *Nguni* people link the efficacy of the traditional healing methods of *ukuhanjwa* to the source of the healing power as well as the principle and function of ritual purification. How the traditional methods are thought to work – the effect of the strong taste and smell, and the conviction that the relevant plant was identified by ancestors as the right plant to use – has already been discussed. Participants such as NoLungisile* are convinced that the traditional medicine for *ukuhanjwa* works:

Kuba ndiye ndasebenzisa eli yeza kuphela waze umntwana wanyangeka, ndiye ndagqiba kwelokuba umntwana unyangwe leli yeza. Esi sigulo senziwa kukuhlangana nomoya omdaka, kwaye ke eli yeza lesintu linyanga kanye umonakalo owenziwe ngumoya omdaka. Umntwana umbona ngokuthi phaka, abuye adlale atye nokutya xa enyangekile.

The fact that I did not use anything other than this medicine for the baby to heal made me conclude that the baby has been healed by this medicine. The illness is caused by contact with the evil spirit, nevertheless this traditional medicine is meant to heal precisely the damage caused by the evil spirit. The baby begins to regain strength and liveliness as well as the ability to play and eat food again as a sign of successful healing.

The evil spirit the participant here refers to is of course the familiar which is believed to have entered the body. Belief in the efficacy of the traditional healing methods of *ukuhanjwa* has resulted in most households using "dual methods"; the indigenous and indigenized, as well as Western modernity (Whiting, 1977, p249) in an attempt to maintain ritual purity, ward off evil and to "cover all bases".

We see that the role of the indigenous medicines is to repel spirits, rid the body of spiritual pollution and restore a state of health. Genuine Seal Oil, toothpaste and shoe polish are examples of indigenized medicine as explained under section 4.5. Wagner (1975, p55) referred to indigenization as the relativization of foreign practices or materials, resulting in a conscious counter-invention to suit people's mode of objectification. The efficacy of all these traditional healing methods is recognized only by those who strongly believe in them in the face of all that the Western scientific worldview has achieved. Indeed, the dominant Western scientific

approach has achieved the "paramount position as the uniquely legitimate interpreter of nature" (Morley, 1978, p6). Those who subscribe to the Western system of healing would mostly doubt whether *'abantu'* illnesses even exist, let alone their cures.

The traditional healing methods for *ukuhanjwa* may be classified as methods of ritual purification as well as 'cooling'. From the Western worldview the idea that these methods "purify" may seem anomalous. The methods would be viewed as unhygienic, with serious potential to worsen the situation. As far as cleanliness or purity are concerned, the difference between the two understandings may, according to Douglas (2010, pp9-10), be differences in linguistics and require a change in word choice. The traditional Southern *Nguni* understanding of ritual purification does not literally mean physical cleansing but an act of expelling spiritual pollution, with a view to healing holistically – both spiritually and physically. Hence the pluralistic tendencies by Southern *Nguni* people regarding the healing method; they would be hoping for holistic healing – spiritual and physical - for the victim.

5.9. Summary of the chapter

Illness has always been viewed as a deviation from the expectations of society. The implications of illness and disease for the individual are that of an urgent need for healing, so that the ill person recovers as soon as possible, and resumes responsibilities as a member of a family and of society.

Ukuhanjwa has not been viewed as the kind of illness which can cause disturbance of equilibrium in social relation but instead it brings family members together in an attempt to heal

the ill person as no person has ever been blamed for causing the illness. Only the familiars are blamed as the cause of *ukuhanjwa* without the volition of the witches. Traditional people are known to believe in the use of material objects in healing. Hence an example has been given of a certain porridge which was originally used to quench thirst and hunger by a traditional faith healer, but after her death, people continued to brew it and led ill persons to believe that the porridge was spiritual, having the ability to heal spiritual or cultural illnesses. Clothes of the ill person could also be taken to the faith healer to be prayed for as the belief was that 'sympathetic magic' would play a role in transferring the healing power from healer to the garment to the ill person who is going to wear the garment.

Every society or culture has its healing methods, beliefs, institutions and cosmology regarding illness and healing. It is always a cultural practice – all medicine is, in this respect, ethnomedicine. Culture influences illness experiences for the various groups, resulting not only in different interpretations of the same illness but in different illnesses altogether. The different cultural interpretations have led to the development of different cultural norms and social institutions that answer the needs of a particular society.

Methods used for healing *ukuhanjwa* arise therefore from the entire worldview of the Southern *Nguni* people. The culture strongly embraces the spiritual, and their methods of healing, too, are essentially spiritual in nature, while also reflecting a strong link with the created order. The source of power of the healing methods is believed to be God's "divine signature" within the plants that are used, evidenced by their bitter taste and smell, which enhances the functioning of 'sympathetic magic'. The same 'sympathetic magic' works for the decoction of the familiar to be

able to chase away the familiars from reattacking the victim until full recovery has been achieved from the illness. The odour of the familiar decoction in the victim would confuse the familiar thinking that the victim is one of them and in that way would help repel the familiar preventing it from reattacking the victim. Ancestors in this regard only function as the messengers of God in delivering the message to the diviners on which traditional medicine is responsible for healing which illness.

Another source of the healing power is acknowledged to be the strong belief and faith in the healing method for *ukuhanjwa*. This faith is related to how the illness is perceived – it is a spiritual cure for an ailment which is essentially spiritual in nature. Familiars are thought to enter the body in a spiritual form, causing disorders throughout the body and especially in the area where they entered – the anus. To counteract this, a strong medicine is needed which has spiritual power and which gives evidence of its spiritual power physically, in its strong smell and taste. The social disruption which this illness causes is minimised in that the attack by the familiar is not seen as the fault of the familiar's owner. No human is held responsible. For the cure to work, in fact, a great deal of trust between parties is required. In many ways the healing process is both evidence of, and an opportunity to further strengthen, social bonds. Hence even trust in the person who is recommending the healing method for the illness plays a significant role regarding efficacy of the healing method, be it the traditional healer or the elderly person.

The third source of the healing power is in the ritual timing in healing the ill at home for the mild ukuhanjwa to prevent it from escalating to severe *ukuhanjwa*. Ritual timing is also significant in

healing of the ill by the owner of the familiar, *ichanti* snake, in the case of severe *ukuhanjwa* to prevent it from escalating to the death of the victim.

The fourth source of the healing power is in the ritual space from where the traditional medicinal plants are supposed to be picked. Emphasis was made that the traditional medicinal plants should be picked from the field and outside the premises of the homesteads as the belief is that witches and their familiars often move about within the homesteads when they intend to attack the victim tramping on these medicinal plants causing them to lose their healing power. Hence the trick is to pick the traditional medicinal plants outside the premises of any homestead for them to retain their healing power.

Southern *Nguni* people insist on the invisibility of *ukuhanjwa.* By this they do not mean the symptoms, which are plain to see, but the cause, the mechanics of the illness and its solution. One of the reasons why this idea of its invisibility has persisted may be related to the fact that traditionally, Southern *Nguni* people visiting a healer do not explain their symptoms. The healer, in this case a diviner, is expected to know the symptoms. When transferring this approach to the Western biomedical system, they find that the doctor cannot do as expected; he or she cannot 'divine' the symptoms. A disappointing result follows. Almost nothing is explained and in return almost nothing is gained. As a result people do not take cases of mild *ukuhanjwa* to biomedical centres, so that doctors never get to see the illness in its mild stage. They see it only in its severe form, by which time it is usually too late. And so the sickness remains in a practical sense 'invisible'.

The holistic nature of the traditional cure for *ukuhanjwa* is apparently its strength. Southern *Nguni* people are not looking only for a physical cure, but a more far-reaching cure that gets to the root of the problem – the spiritual dimension. In this area, they remain more closely linked with their religious beliefs than do many Western Christians, who often treat illness as a purely mechanical problem with no bearing on the spiritual dimension at all. Southern *Nguni* people believe that the healing in the plants they use comes from God through the intermediaries of diviners. Their actions taken to effect healing are essentially "religious" actions, affirming their cosmology.

Diviners get their knowledge from ancestors, and ancestors get their knowledge from God. Once diviners have the knowledge, they pass it onto herbalists, who pass it onto families in need. So each part of the spiritual and temporal worlds plays its part, and the afflicted family merely uses what it is guided to use in this "chain of knowledge" coming originally from God.

Indigenous concoctions from medicinal plants and decoctions made from the familiars responsible for causing the illness, as well as indigenised methods such as genuine seal oil are the most commonly used cures for *ukuhanjwa* amongst the Southern *Nguni* people. Genuine seal oil and the concoction would be used for mild *ukuhanjwa* whilst the decoction would be used for severe *ukuhanjwa*. The efficacy of these healing methods lies in the source of the healing power and the principle of ritual purification. But it should be noted that 100% healing has been guaranteed by the Southern *Nguni* people for mild *ukuhanjwa* unlike for severe *ukuhanjwa* whereby less than 50% healing could be achieved.

An issue which has been brought to light here is the almost complete lack of concern for pre-empting what is perceived and experienced to be a fatal illness. The whole healing framework is reactive rather than pre-emptive. The response to the illness by Southern *Nguni* people could send confused signals to biomedical health workers; when an illness is taken as seriously as *ukuhanjwa* evidently is by Southern *Nguni* people, one might expect a more thorough response, including the development of pre-emptive measures. It seems be fairly common amongst Southern *Nguni* people to adopt this approach – other illnesses too, are treated reactively rather that pre-emptively. The approach seems to be playing a role in the tragedy of the HIV/AIDS phenomenon, where prevention methods are known but not adopted wholeheartedly. It is possible that this *laissez faire* approach to maintaining health over the long term reflects a deep belief that life is essentially benign; that disasters are not expected to take place, and that to maintain health and happiness one needs merely to live in harmony with one's community, rather than take active steps to achieve what is already one's birth right – good health and happiness.

CHAPTER 6: THE INVISIBILITY OF *UKUHANJWA* WITHIN THE BIOMEDICAL HEALTH SYSTEM

6.1. Overview

The chapter looks at the phenomenon of the "invisibility" of *ukuhanjwa* to the biomedical health system within the context of the power relations between the two medical systems – the biomedical and the traditional. The hegemony of the biomedical health system, the forces of globalisation that led to this hegemony and the responses of the Southern *Nguni* to this dominating position are looked at, as is the influence of poverty on health-related help seeking. The concept of witchcraft as an evidence-based theory is examined, as is the Southern *Nguni* contextual meaning of 'invisibility', and the biomedical response to that 'invisibility'.

It begins with defining 'invisibility' as having both a literal meaning and a contextual meaning in relation to *ukuhanjwa*. The 'invisibility' of *ukuhanjwa* to biomedical diagnosis can be regarded as part of a discourse which needs to be entered into in order to make sense of the concept; it needs to be viewed within its "historical, political or cultural setting" (Lupton, 2012, p2). This discourse should also include the concept of ritual purification, for without such discourse the term is apt to be seen as directly contradicting the literal meaning of the word "pure", as explained by Good (2001, pp92-103).

The chapter also addresses the phenomenon of the pluralistic approach to health and healing, an approach which has been found to be popular in other developing countries, such as India (Whiting, 1977, p249). Lastly, the chapter addresses the linkage between the perceived source of

the traditional healing power and the continued use of traditional healing methods for *ukuhanjwa*.

6.2. Interpretations of illness and discourses on power structures in illness, health and medicine

The section addresses the issue of various interpretations of illness and how these relate to power structures within illness, health and medicine. Despite the existence of a dominant healing method, and the vigorous way in which it is promoted by governments the world over, it is always the meanings that people attach to their illness experiences which determine the healing methods they choose.

6.2.1. Power relations and discourses in illness, health and medicine

Illness, health and medicine are politicised fields in this era of a huge concentration of power in the hands of few. Globalisation has ensured the dominance of a particular world view and healing system which are inextricably bound to political and economic factors. Hence the interest of medical anthropologists in how health and medical language relate to power (Lupton, 2012, p12)

The nature of diseases and their cures, and the process of identifying and labelling diseases, has been dominated by the biomedical health system to the point where it is unable to recognise any other interpretations but its own. It is unable to recognise, name and cure *ukuhanjwa*. Faced with this reality, it strives to treat symptoms as they have been discussed in chapter 4, but not the

disease itself. The biomedical response to these symptoms would be to treat each one individually. They would see the wide open anus as a result of diarrhoea or sexual assault, and advise accordingly. Usually they dispense paracetamol or acetaminophen (the generic name) under the trade name Panado, to bring down the temperature where the *ukuhanjwa* is mild. The traditional approach would be to get to the root of the problem and deal with all symptoms at once. It would be a truly holistic approach.

To name the illness is to diagnose the illness. Once the name is known, the symptoms are understood, the cause is known and the treatment is straightforward. To the Southern *Nguni*, the illness is known as *ukuhanjwa* from *uku* meaning "to" and *hanjwa* meaning "penetrate". Thus, literally, "to penetrate", and idiomatically, "spiritual penetration". This name arose, as do all names for illnesses, from shared experiences and the common worldview of a particular group. The first point of check for the Southern *Nguni* people when performing their diagnostic procedure for the illness is the anus, which they would check to ascertain whether it is wide open or not. If it is wide open, then spiritual penetration by a familiar is immediately recognised and the illness is named and dealt with accordingly. As Nobom* said:

> *Zizilwane zokuthakatha. Zizo ezingunobangela wesi sigulo ngokuthi zingene ngaphakathi zimdle umntwana kuwo nawuphi umngxuma ezizikhethele wona. Kaloku indawo yokuqala esijonga kuyo ziimpundu thina. Ukuba iimpundu azivulekanga, kuba nzima ukuba sikhawuleze sazi ukuba lurheqo.*
>
> It is the familiars. They are the cause of this illness by penetrating inside the child through any bodily opening of their choice. Our first point of check is the anus. If the anus is not wide open, it becomes difficult for us to quickly identify it as *ukuhanjwa*.

Biomedical practitioners do not share the name for the condition because they do not recognise the cause as a valid one. To them it is a collection of symptoms without a name – a non-illness. As a non-illness, it cannot be treated effectively. The Southern *Nguni* way of interpreting the non-comprehension of biomedical practitioners of this condition is that its true nature is invisible to them. They observe that biomedical practitioners examine and try to heal individual symptoms instead of providing a medicine or healing method which will simultaneously heal all the symptoms and chase away the evil spirits. Thus the nature of the diagnostic system used determines whether the illness is cured or not. As Zamile* of Mhlontlo Local Municipality (MLM) in the ORTDM says,

> *Isilungu asisebenzi kwesi sigulo. Sisigulo sesintu esi, ngoko ke sifuna ukunyangwa ngesintu. Isilungu sinyanga inyama, kanti isintu silwa nomoya omdaka sisilande ezantsi isigulo. Isintu sisebenza nonobangela wesigulo.*
>
> The Western healing methods do not work in healing this illness. This is cultural illness - hence it needs traditional healing methods. The Western healing methods heal the physical body whereas traditional healing methods target even the evil spirits, extracting the illness from the deepest parts of the body. Traditional healing methods also work on the causes of the illness as well for holistic healing.

NoLungisile* elaborated more on the uniqueness of the medicine and healing method for *ukuhanjwa*:

> *Kulo mxube umntwana umseza i-teaspoon kuphela ze emva koko umkhamele ngamaqabaza eli yeza kuyo yonke imingxuma ze eshiyekileyo umcime ngayo. Umcimo kufuneka umncinci ngoba akacinyelwa ukuba ahambise, koko kufuneka likhe lihlale*

lisebenze apha ngaphakathi ukuze xa liphuma likhuphe ubushushu nokungcola okwenziwe sisilwanyana eso.

From the concoction, a child should be given only a teaspoonful, and the remaining concoction should be used to apply small droplets to all bodily openings of the victim and as an enema. The enema has to be a small amount, not for purging the victim, but to allow it to cleanse his/her internal organs so that when releasing the bowels it comes out together with the evil spirit and the heat, which resulted from the contact with the familiars, for the victim to cool.

What stands out in this method of healing is that there is no attempt to focus on this or that particular symptom; it is always seen as a collective of symptoms, healed simultaneously.

Seemingly, it was originally important for the Southern *Nguni* people to get the biomedical health sector to understand their illness, and it troubled them that biomedical practitioners continued to dispute its existence. Hence they resorted to the belief that the illness is invisible to the biomedical world. Comparisons between the two approaches would be quite unfair, as they arise from such totally different worldviews. And yet with this particular disease, it does seem that traditional medicine has the upper hand. It has the record of curing from the contextual meaning of the Southern *Nguni* people, whereas the biomedical approach does not.

Linguistics in medicine, of course, reflect the culture from which the medical system arises. The way people speak or the visual metaphors they use often cause confusion, misconceptions and misinterpretations. The “pattern of words, figure of speech, concepts, values and symbols”

(Lupton, 2012, p2 and Douglas, 2010, pp9-10) all contribute to different meanings attached to phenomena, as the case with the phenomenon of cleanliness or purity. The Southern *Nguni* concept of ritual purity has sometimes erroneously been equated with hygienic cleanliness (Ngqila, 2002), resulting in misunderstandings. To the Southern *Nguni*, purity and cleanliness in medical matters refer to spiritual cleanness, and the use of anything which brings about this state of spiritual cleanness. This includes appeasing ancestors, warding off pollution and healing the ill. It does not mean sterile, free of germs, "clean" in the physical sense.

Thus we see that different cultural groups developed ways of 'making sense' of illness, health and medicine from their own cultural perspectives, based on historical, political, economic and cultural settings which cannot be compared, as already stated. As a way to rationalise the great disparity that exists between their own traditional methods and biomedical methods, traditional Southern *Nguni* accept that some healing methods specialise in physical healing while others specialise in spiritual healing. This allows a place for both.

The manifestation of power relations in the field of health and illness can be seen in the way a stronger culture has come to dominate the discourse on health and healing. Strategic approaches are used by the dominant culture to penetrate the culture viewed as inferior and weaker, for the purpose of social change. One of the strategies used by the South African government as a way of overpowering those who subscribe to traditional healing methods, has been to introduce laws forbidding people from withholding treatment from biomedical health centres to children. Adults are still allowed a choice, according to Nosimo – a community member and a nurse, but when it

comes to children, it is a requirement of law that every means possible be made to cure the child biomedically.

An interview conducted with Nosimo*, aged 45 and a professional nurse in a hospital in Nyandeni Local Municipality (NLM) in the OR Tambo District Municipality (ORTDM), explained how this worked in practice:

> *Amalungelo omntwana ayakhuselwa sisibhedlele kunye namagqwetha aso ingakumbi xa engekakwazi ukuzithethela. Siyamnika ithuba loba awasebenzise amayeza akhe esintu lo umdala umntu kodwa sinike isithuba esingangeeyure ezine phakathi kokusetyenziswa kwamayeza esilungu nawesintu. Kwaziwa iiyure ezine ilithuba elaneleyo lokusebenza ngokupheleleyo kweyeza lesilungu. Asiwamkeli amayeza esintu kwaphela kunjalonje siye simxelele umntu ukuba xa elisebenzisa elo yeza lesintu, ulisebenzisa ukuze azisole yena angasoli isibhedlele*.
>
> Children's rights are protected by the hospital and the hospital lawyers, especially when the child is still unable to speak for himself. We do give a chance for the use of traditional medicine to adult people but allowing four hours in between use of biomedicine and traditional medicine. The understanding has been that four hours is the lifespan for the functioning of the modern treatment. We do not accept use of traditional medicine at all, such that we usually inform a person that when using traditional medicine, she or he would be using it at her or his own risk and should not blame the hospital.

But the same interviewee, Nosimo*, narrated another story which contradicted the above statement regarding the legal requirement to treat a sick child in hospital. She described a case where parents had refused medical treatment for religious reasons, resulting in the death of the child:

> *Kodwa kwenzeka ukuba abazali bomntwana bamalele ukuba asebenzise unyango lwasesibhedlele ngenxa yenkolo yabo bambukela umntwana wabo esifa phambi kwabo endaweni yokunika isibhedlele ithuba.*
>
> But it happened that one couple of parents refused successfully to allow the child to be treated using the biomedical approach because of religious reasons and watched the child die in front of her instead of giving a chance to the biomedical method of healing.

In addition to the story above, another participant, Nosimo*'s colleague, in a group discussion which was held at Nyandeni Local Municipality, narrated a similar story where another parent collected her child from hospital in preference for traditional medicine:

> *Kwakusekulithuba noko sizama ukumnyanga lo mntwana engade aphile. Wafika unina esibhedlele esithi umntwana wakhe uhanjiwe lichanti kwaye kukho umntu othe angamnyanga watsho ecela ukuhamba naye. Wacacisa ukuba lo mntu uza kunyanga umntwana wakhe ngumnikazi wechanti. Sazibona sesimkhululela nathi ngoba sasixakiwe kukudala sisama ukumnyanga singaphumeleli*.
>
> It was after a long while that we have been trying to heal the child without success. The mother of the child arrived at the hospital stating that her child has been attacked by the familiar called *ichanti* (a male snake believed to be for accumulating wealth) and that someone has offered to heal the child and she asked for permission to leave with the child. She explained that the person who offered to heal her child was the owner of the

ichanti snake. We found ourselves releasing the child because we were also confused as we have been trying to heal the child for a very long time but without success.

Regarding the two cases above, the question arises whether, if instances such as these are allowed to happen, the protection of children's right to medical care is theoretical only. The incidents confirm what was stated by Mofokeng (2003, pp15-16); that some medical practitioners are themselves confused as to what to advise, when they have been exposed to a variety of cultures and experience cultural conflict. In this regard, the two nurses had a responsibility to abide by the rules of biomedicine, but because they have been exposed to traditional practices too, they found themselves bending the biomedical rules and releasing the children to their parents. One child died and the other child was healed as a result of the use of traditional care. As Levine (2012, p86) says, even though biomedicine is accepted as authoritative, its knowledge is not always uniformly shared and practised by all its practitioners. This, according to Levine (*op. cit.*), leads to different diagnostic and therapeutic possibilities, as in the cases above where one child died and the other was healed – independently of the biomedical contribution.

This leads to the consideration of ethnocentrism and relativism. Although lip service is paid to the ideas of relativism, with biomedical practitioners encouraged to understand the so called inferior and weaker cultures, in reality the ethnocentric approach of biomedicine usually swallows up all other considerations. The biomedical health centres are clear about what they want to achieve in terms of bringing about social change in the area of illness, health and healing. They would like the wholehearted adoption of biomedical healing methods without any

pluralistic tendencies. There are however exceptions in private practice. During interviews in ORTDM, the researcher was told of two biomedical practitioners who attracted a large following by adapting their own healing methods to the needs of people presenting with *abantu* illnesses. These two biomedical practitioners, one a black African man and one a white man from abroad, started working together in Tsolo and later in Mthatha. People would travel from all over the ORTDM to these two doctors, because they showed unusual sensitivity to patient's worldviews and understandings of their own conditions. They listened carefully to the language of the local people over a number of years and were able to pick up the terms they used for illnesses. They then indigenised certain biomedicines such as *udupha* or *ivimbela* to suit the needs of the traditional people. One of the interviewees from MLM (Tsolo area), Nokwakha*, mentioned that she took her children to these practitioners whilst they were still in Tsolo for all *abantu* illnesses such as *ukuhanjwa,* and their treatments worked:

> *Ngamanye amaxesha ndandisebenzisa udupha okanye ivimbela. Uyaqhunyiswa ngokubekwa emlilweni. Ufumaneka kwiqhaga elifana nele* rubbing stuff. *Ndalifumana kugqirha wesilungu onolwazi ngeendlela abantu abantsundu abasebenza ngayo. Babedla ngokuthi eli yeza libukhali ekugxotheni umoya omdaka. Ndandibazi abagqirha ukuba bayasinyanga isiXhosa. Lalisebanza kakuhle iyeza labo ingakumbi kubantwana abangaphantsi konyaka*.
>
> Sometimes I used doepa or *ivimbela*. You were required to burn it on the fire. *Ivimbela* was found in a small container which looked like the container used for rubbing stuff. I got it from a biomedical practitioner who had knowledge about ways black people used to heal. They used to insist that the medicine was exceedingly good in chasing away the

evil spirit. I knew that those practitioners were able to heal *abantu* illnesses. Their medicine was working well especially with infants.

The indication is that traditional people were looking for someone who would listen to what they said from their perspective; who would know and share the contextual meaning and interpretation of illness, and who would accept their language in the field of illness and healing – hence the biomedical physicians decided to give them indigenised medicine. When the researcher visited one of these practitioners who is currently practising alone in Mthatha, he told of how traditional people who came to him for treatment would adopt the practice they used when consulting diviners: they would sit in front of him and not say a word. His assistant had to explain this to him:

Xa siye emagqirheni ethu asithethi koko ligqirha elithethayo lichaza ingulo yomguli.

When we visit our diviners we do not talk, instead it would be the diviner who would talk, stating the nature of the illness of the patient.

This inspired the biomedical practitioner to purchase a diagnostic machine which could take the place of the diviner as a scanner. The patient sat on the chair and the chair would be able to detect and indicate possible illnesses such as the level of blood pressure, diabetes and others without the patient or practitioner having to say anything. The patients ended up naming the machine as *igqirha* (the diviner). But unfortunately, the biomedical practitioner avoided mentioning the name of the machine and seemingly he is still the only one who has the machine in Mthatha. Even when the researcher tried to inquire about the name of the machine from other biomedical practitioners, they could not tell as they indicated that they have never heard about such machine. The researcher saw the machine which resembled the chair where the patient

could sit comfortably for the machine to detect the possible illness. In this regard, the researcher had no choice but to respect research ethics whereby the participant has a right not to divulge the information if he or she feels uncomfortable to do so.

The pluralistic approach to healing is frequently the answer for many people who feel the attractions of both approaches. In the research for this study, it became clear that sometimes, traditional methods are used when biomedical healing methods have failed; but in many cases, traditional methods are the first and most trusted method, particularly when an illness is seen as purely cultural. In such cases biomedicine may not be tried at all.

These findings contradict the assumption shared by most Westerners that people automatically abandon their traditional medicine when acquainted with Western medicine, as assumption pointed out by Schott and Henley (1996, p17).

The findings support what was argued by Gordon (2010, pp165-183) and Varga and Veale (1997, pp911-924) that people continue using traditional medicine despite biomedicine's hegemonic attempts to prohibit such practices. Hence the biomedical health centres even appear to be contradicting themselves as explained above, for while they are adamant that they do not promote the use of traditional healing methods, they ask adult patients to use their traditional medicine a miminum of four hours after the biomedicine has been consumed. Local people have confessed that they continue with the use of traditional healing methods in their homes for spiritual healing, despite the prohibitions of biomedical practitioners, as they strongly believe in the existence of spiritually-caused illnesses. Traditional people have demonstrated their

scepticism regarding foreign or biomedical healing methods for *abantu* illnesses. This confirms assertions by Perret (2010) and Wedel (2009, pp49-64). One of the male participants in this study, Zolisile*, 65 years old and a pensioner from Ingquza Hill Local Municipality (IHLM), concurred with other participants who were present when he stated that:

> *Impilo yakho lisiko lakho, ngeke simyeke undalashe. Iyeza lesilungu liyadambisa nje kanti elesintu lona liyilanda phansti ingulo ezingcanjini. Nangona oogqirha besilungu bekhweleta nje angeke siyekwe isintu*.
>
> Your illness and health is your tradition and custom - we shall never abandon tradition. Biomedicine only controls the illness but traditional medicine heals the illness together with the root cause of the illness. Although biomedical doctors tend to be watchful, traditional healing methods will never be abandoned.

In biomedical healing, experimentation and scientific evidence in the laboratory reveal the causes of illness and determine the healing method. With the so-called theological, metaphysical or traditional healing methods, enculturation ensures the continued belief in the causes and cures of illness over decades and indeed centuries, and this longevity of the practices is evidence enough to sustain their belief system. Biomedical healing is always the most popular with governments, with political support related to tangible evidence of successes. As far as governments are concerned, there is no place for metaphysical healing methods as their evidence is intangible and undocumented. In this case, it is deemed intangible despite the extended period of continued use and the strong belief systems around illness, health and medicine. Because the evidence is not recorded, or accepted, it is deemed an inferior practice and the categorisation into superior and inferior cultural medicine – ethnomedicine - begins to take shape.

6.2.2. Witchcraft as evidence-based theory amongst the Southern *Nguni* people

It has already been indicated, *ukuhanjwa*, the spiritual penetration of a victim by a familiar, is regarded as an unintended and unpredictable affliction, hence the lack of measures taken to prevent it from happening. When it comes to causing sickness and misfortune, witches are believed to have no boundaries. Once there is enmity between a witch and an individual, the belief is that the witch will attack his or her enemy from all directions, either by hurting the person directly or hurting the person's loved ones. It could be the person's child, mother, siblings or relatives – but the witch will target someone. The Southern *Nguni* believe in the existence of both white and black witches. White witches have evil thoughts but little power to act. They wish misfortunes upon people – thus demonstrating the power of evil thoughts – and these misfortunes frequently take place by an indirect route. As a result Southern *Nguni* people would generally not mention plans for the future until these plans are realised. Hence women rarely mention a marriage proposal to people they do not trust, until the day of the marriage ceremony, or until they are already married.

Black witches are believed to have the spiritual power to create evil animals (familiars) and perform direct actions to harm their enemies by bringing all forms of misfortune in their lives, whether in the form of accidents, illnesses, deaths, conflicts between relatives or poverty. These misfortunes may be entirely blamed on the witches. The belief is that ancestors are there to protect people and never to harm them. When people disregard customs, norms and traditional values, ancestors become angered and withdraw their protection, allowing opportunistic witches to attack. In cases where it is believed that misfortunes occurred as a result of a withdrawal of

ancestral protection, the victim would be advised by the diviner to first perform a ritual to appease the ancestors, and then seek healing for the misfortune.

The most feared is of course the black witch. One individual even differentiated between the normal cat and the spiritual cat which is used as a familiar by witches, stating that the normal cat is known to have quiet footsteps whilst the spiritual cat would have noticeably loud footsteps. Black witches are also believed to have the ability to enter the bodies of spiritual animals thus taking the form of familiars. An anecdote regarding this magical ability was given by one of the participants, Nosethu*, from MLM at Qumbu Village. She told of a witch who had confessed to her own daughter:

> *Watwela umfazi echaza ukuba ubekunye namanye amagqwirha apho kuqgitywe kwelokuba ngumjikelo wakhe ukunikela ngomnye wabantu abathandayo ukuze abulawe nanjengoko ibisaya kuba lisiko labo ukwenza kanjalo njengamagqwirha ze bacebisa ukuba ibe yintombi yakhe anikela ngayo. Uthe ngokothuka wayichazela intombi yakhe ngesigqibo eso eyixelela nangexesha abazofika ngalo ebusuku apho endlwini yentombi yakhe bengamasongololo amathathu. Phakathi kwaloo masongololo yena uyakuba esesizikithini sawo besihla besuka eluphahleni lwendlu, waza wamchazela kanye nendawo abaza kuphuma kuyo eluphahleni. Nangona wayengayikholelwa ukuba unina angaligqwirha, wagqiba kwelokuba awalindele loo masongololo. Intombi yabasa isitovu yasibeka kanye malunga nale ndawo amasongololo, kunye nelo lizobe lingumama wayo, azowela kuyo. Ngaphezulu kwesitovu yabeka imbiza enamafutha ukuze iwabilise ukuze amasongololo xa esiwa esuka eluphahleni atshele apho emafutheni. Ngokwenene amasongololo afika kanye ngexesha ebelibekiwe aze awela apho emafutheni abilayo*

atsha. Intombi yakhawuleza yalikhupha eli lalisesizikithini isongololo lawayeka amanye amabini ukuba atshe ade afe. Ngentsasa elandelayo umama wentombi leyo wafunyanwa etshile waza watwela echaza ukuba utshe njani kungekho mlilo. Abanye abafazi aba babekunye nomama wentombi leyo begqibe kwelokuba bayobulala intombi yomlingane wabo ngobusuku obo bangephezolo, bafunyanwa befile kwintsasa elandelayo, ngale ntsasa kwafunyanwa ngayo umama wentomi naye etshile.

The woman confessed that she was with other witches when it was decided that it was her turn to give one of her loved ones as a sacrifice to die as it was their common practice and ritual to do so as witches, and a suggestion was made that it should be her only daughter. Panic stricken, she told her daughter about the decision indicating the time they would arrive during the night at the daughter's place in the form of three *amasongololo* (millipedes). Amongst those three millipedes, she would be in the middle dropping from the roof, and also indicating the section of the roof from where they would be coming. Although she did not believe that her mother could possibly be a witch, she decided to wait for those millipedes. The daughter lit the stove and placed it below the section of the roof from where the witches including her mother would be coming. On top of the stove she placed a pot of cooking oil for it to boil so that when the millipedes dropped from the roof, they would burn in the cooking oil. Indeed the millipedes came exactly at the time which was indicated and dropped into the boiling oil. The daughter quickly removed the middle millipede and left the other two to burn to death. The following morning people found the daughter's mother badly burnt. She confessed about how she got burnt without the visible fire. The other two women who were claimed to be together with the

daughter's mother were found dead in the following morning, the same morning the mother of the daughter was found burnt.

Nosethu*, who related this incident, was 50-years old and had attended school up to grade 11. This would be an indication of some degree of acculturation, yet her belief in witchcraft was deep and strong, indicating that literacy has little effect on traditional beliefs. It is matter of enculturation over millennia and is not removed by Western education.

Other confessions by witches serve as evidence for their existence, particularly with regard to *ukuhanjwa*. Nobongile* was the elderly lady mentioned in Chapter 4, who described her initial encounter with *ukuhanjwa* when she visited her polygamous grandfather's place:

> *Waguqa ngamadolo umfazi omdala katat'omkhulu endithe ntsho emehlweni ezama ukucacisa ukuba izilwane ezo azithunywanga ngabo bengabafazi bakatat'omkhulu, koko bezizihambela nje zaza zahlangana nomntwana lowo ngengozi. Wacacisa ngelithi "asimdli thina umntwana womnye umntu ingakumbi oyintombazana, sidla amakhwenkwe azelwe yindoda yethu kuphela. Nokuba ebeyinkwenkwe lo mntwana wakho, besingazumdla, ngoba sidla amakhwenkwe azelwe yindoda yethu kuphela. Yiloo nto indoda yethu inabantwana abangamantombazana kuphela".*
>
> "The eldest wife to my grandfather knelt down, looking me straight in the eye, trying to explain that the familiars were not sent by them as my grandfather's wives, but were just loitering about and accidentally came into contact with the child. She explained that "we do not harm another person's child especially a girl child, but we only harm the boy children born of our husband. Even if your child was a boy, we were not going to harm

him, because we only harm boy children born of our husband. Hence our husband only has girl children".

For the Southern *Nguni* people, the evidence of a confession like this is tangible enough to qualify witchcraft as real. Obviously, this approach to evidence cannot be compared with evidence as conceptualised by the biomedical health system.

6.2.3. Dealing with illness and disease

How a person responds to illness and disease depends entirely on his or her worldview. A worldview may be shaped by many factors, some of them contradictory, and may result in an approach which we would call pluralistic. This may be seen as an attempt to reconcile apparently opposing views. The traditional, pluralistic and biomedical approach all involve a form of ritual, though varying greatly. *Ukuhanjwa* is so unique a condition that it tends to be identified as a case for spiritual remedies first and foremost. One of the reasons for this is the strange anomaly of the presence of quite serious "wounds" but no accompanying pain. The lack of pain is evidence in many people's minds of the work of the evil spirit. Siziwe*, in chapter 4 highlighted her amazement of the fact that there could be all the symptoms of *ukuhanjwa* but no pain:

> *Akaqaqanjelwa phofu lo mntwana, kodwa uya kufika ebhontshiza. Esi silonda / inxeba sakhe silapha ngasemva siqala ngokuba sisitshitshilili samaqhakuva, ze ethubeni ahlangane abe sisilonda esivele sithi bhedu ngequbuliso ngethutyana nje elifutshane. Yiloo nto ke siye siqiniseke ukuba uhanjiwe ngoba sube engaqaqanjelwa futhi engophi nokopha.*
>
> The child would not be experiencing pain but would continue to be restless. The 'wound' around the anus would start by being a ring of pimples which would be later joined to

> form the 'wound' which would suddenly appear within a very short period. That is exactly the reason why we would be convinced that it is the *ukuhanjwa* because the child would not be experiencing pain and would also not be bleeding.

Here we see how the clash of cultures immediately becomes apparent. For traditional people there is evidence enough that this is a spiritually-caused illness. Help seeking will be based on one's perceptions of the cause. Here the caregiver would perceive the illness to be spiritually caused based on his or her pre-existing conceptual foundation, coupled with diagnosis by the diviner, shared experiences by the society and interpretations and meanings of previous illness experiences by the caregiver, as elaborated on in previous chapters.

6.2.4. Interpretations and meanings of illness experiences

The Southern *Nguni* people hold a belief that witchcraft or any form of supernatural activity has the potential to harm people. This belief is enculturated and lives independently of educational level in many respects. In order to avoid being accused of ignorance and disrespect for cultural beliefs, younger people submit to their elders' guidance on how to deal with *ukuhanjwa*. The interpretation of a particular incident or illness depends on the social construction of illnesses in general. An example can be made of an elderly woman, Vuyelwa*, who participated in interviews on *ukuhanjwa* when she was 72. She was a well-educated person with a degree in education and a retired school teacher. She told of how she had developed a small pimple on her leg which she did not take seriously until it developed into a wide circle of black pigmentation. She had not experienced any pain and to her this was significant, and an indication of witchcraft; it being the intention of witches that she would disregard the wound, until it caused complete

dysfunction of the leg. Her expectation was that a natural illness would be accompanied by pain; the lack of pain was mysterious, indicating the witches' strategy to mislead her so that she would not take action. When advised to visit the biomedical health centre, she refused and immediately gave her own interpretation of the cause:

> *Ndatsiba umkhondo owawubekelwe mna ngamagqwirha ndisemncinci ukuze ndilimale ndibe nako nokugula*.
>
> I walked over a spell which was set for me specifically by the witches at my younger age so that I would be harmed and fall ill.

Based on her interpretation of the cause, her conclusion was that the biomedical health centre would surely attach an incorrect name to the illness and attempt to heal her, but would not succeed. The true nature of the illness would be 'medically invisible' to biomedical diagnosis.

Her interpretation of the illness led her to decide to apply traditional medicine to her wound without hesitation. She used the leaves of the sweet potato. She crushed the leaves to extract the juice which she applied directly to the wound on a daily basis for about a week, causing the wound to burst open and release a black fluid. Release of the fluid brought healing. Her interpretation of the experience was that:

> *Yile ncindi yale bhatata le incedileyo ekukhupheni eli bekelo liyile ncindi emnyama. Lalibekelwe mna ngamagqwirha*.
>
> It is the juice of the sweet potato which assisted in releasing the spell in the form of the black pigmented liquid. It was set for me by the witches.

That the wound got healed after the application of the medicine confirmed, in her mind, her initial diagnosis and interpretation. She visited a hospital only two years later, after suffering a stroke, when she had no choice but to submit as she had fallen down and was unable to speak.

In the case of *ukuhanjwa*, the Southern *Nguni* people link the illness with the spiritual penetration of a familiar into the anus, genital opening and other bodily openings, as they have no other explanation for the wide opening of the anus, especially that of a child. The normal and natural state is for a child to be highly protected by the ancestors. Children are not expected to become ill or die, and if they do it is an indication of unusual spiritual activity. Children have not yet reached the age of qualifying as an ancestor. The Southern *Nguni* people regard an ancestor as an individual who has died having reached the age of an elderly person, able to demonstrate a deep knowledge and experience of life. That person would be able to be used for the enculturation of others from one generation to the other for the preservation of culture. So illness in a child is already an indication of something unnatural.

A second indication that something spiritual is the cause is the absence of pain. The belief is that lack of pain is intended so that the victim or his caregiver will take no notice of the illness until it reaches the severe stage, when it would be difficult to reverse the situation. The illness is also sometimes referred to as *ukwebiwa* (spiritual stealing of the soul) because the victim would be tired, sleepy all the time and with a weary cry from lack of energy as explained in chapter 4. The interpretation of this unnatural weariness causes people to become alarmed and suspicious when any family member needs to sleep during the day for extended hours. The belief is that extended sleeping may be either an indication that *ukuhanjwa* is already present, or it may simply present

an opportunity for an opportunistic familiar to attack and cause *ukuhanjwa*. Thus even if a person is not a victim of the illness, he or she will be woken up if he or she sleeps too much, and in most cases the anus will be checked. It is an indication of the deep fear surrounding this illness.

Another symptom is the *isilonda* (the wound). The victim would not experience pain according to the mothers interviewed as indicated in chapter 4. To the Southern *Nguni*, the illness appears to be a silent 'attacker' on the lower parts of the body of the victim so that by the time one notices the illness, it would have reached the stage of severe *ukuhanjwa*. Lack of pain while the body of the victim is being destroyed by the illness is their greatest fear. As is the case in the biomedical interpretation, pain is seen as an indication by the body to the person that something is wrong. It is the body's alarm system, forcing a person to pay attention. In this, the traditional interpretation is in agreement with biomedicine. In the case where pain is absent, the Southern *Nguni* people regard that illness as the most dangerous silent killer - hence they have such fear for the illness. Severe *ukuhanjwa* is regarded as a point of no return. Symptoms such as vomiting, the loss of muscle strength in the neck and diarrhoea are associated with severe *ukuhanjwa* and generally indicate that death is imminent. Hence there is so much fear for the illness such that it becomes difficult for the local people of the ORTDM to delay the application of traditional medicine immediately they suspect the illness. To them, taking the victim to the modern medical health centre would mean delay in healing the illness, with fatal consequences.

6.3. Hegemonic tendencies in the biomedical health system

The section discusses the forces of globalisation on illness, health and medicine; the social and political processes leading to the hegemonic tendency of the biomedical health system as well as

the influence of poverty on help seeking. The hegemonic tendency of the biomedical health system is seen as part of governments' strategy to introduce social change in less well-developed societies. Despite biomedicine's hegemony, traditional medicine has stood up to the attempts by governments to side line it and its adherents have refused to "belong to history", Lèvi-Strauss (1983, pp 321-322)

6.3.1. Forces of globalisation on illness, health and medicine

Power relations have everything to do with forces of globalisation. These include issues of economic and political power, and the domination of the biomedical healing system owes much to the support it receives by governments.

The development of biomedicine could be seen as the result of a faster pace of evolution by Western society compared with African society. The biomedical healing system is viewed as being integral to Western culture, with the west recognized as having the economic and political power necessary to enforce its position. The evolution of culture could be linked with the ability of a culture to invent at a faster pace, with the biomedical health system tending to overpower the traditional health system by inventing at a faster pace. These cannot be compared other than by stating that those who subscribe to the biomedical health system are overpowered by and obey the laws of evolution and acculturation, as against those who allow the laws of enculturation to shape their identity, and do not dismiss old beliefs and cultural practices in favour of newly introduced inventions. Hence Lèvi-Strauss (1983, pp321-322) refers to "resistance traditionalism" as refusing "to belong to history". This refusal to belong to history was confirmed by one of the male participants, Zakhele*, interviewed at Xhorhana, Ingquza Hill

Local Municipality (IHLM) in the OR Tambo District Municipality (ORTDM). He was 90 years old at the time of the interview and a husband to the mother who hosted the researcher during the time of collecting data in 2013:

> *Noba bathi basiwayeke amayeza esintu bayadlala ngoba abazusilandela baye emakhayeni ethu apho siwasebenzisa khona. Kwa isigulo esi sokuphambana kunye namafufunyana, abakwazi ukuzinyanga oogqirha besilungu ezo zigulo. Kanti isintu sitsho kuqala simnyange ngokupheleleyo umntu.*
>
> Even if they insist that we should do away with traditional medicine they are just joking because they are not going to follow us to our homes where we use them. Even cultural illnesses, biomedical practitioners are unable to heal these kinds of illnesses. Nonetheless, traditional healing targets such illnesses and heals the ill person first time and completely.

During the time of the interview, Zakhele* was together with the headman of the research area and the wife of the headman who was a diviner. They all concurred with Zakhele*'s assertion stating that:

> *Angekhe siwayeke amayeza esintu singabantu abamnyama ngoba kaloku kukhulu ukuthakatha. Ukugula okuze ngobuthi kunyangwa ngesintu kuphela.*
>
> We, as black people, will never stop using traditional medicine because there are a lot of witchcraft acts. Illness as a result of witchcraft acts can only be healed with traditional medicine.

Schott and Henley (1996, p17) foresaw this reaction when they argued that many Westerners assumed that when people have access to Western medical care they automatically abandon the

traditional system they grew up with – an assumption which these participants have proven wrong. Based on the evidence which has been presented by the ORTDM participants on witchcraft's existence, they believe in witchcraft as being a reality and a threat to their lives – hence their strong belief in traditional healing methods, especially for cultural illnesses. However, the strength and efficacy of traditional medicines still depends on the source of the healing power; ie, whether the patient has been guided in his treatment regime by a diviner who is correctly guided by ancestors, and various other factors. The authenticity of the diviner plays a large part in determining whether or not his methods will work.

6.3.2. Social and political processes leading to hegemonic tendencies of the biomedical health system

During the apartheid era in South Africa, traditional healing and medicines were declared illegal, but at the end of the apartheid era they were politically re-established. However, even with the demise of apartheid, the hegemony of the biomedical health system was still intended to undermine the social status of traditional healers and traditional healing for the purpose of social change and the introduction of a new health system. According to Eastman (2011, p185), Gordon (2010, pp165-183) and Ross (2010, p46), the Traditional Health Practitioners Act (THPA) 22 of 2007 as an amendment of the THPA 35 of 2004 which was introduced to overturn the Witchcraft Suppression Act 3 of 1957, has not completely changed the mind-set and operations of the biomedical health workers and biomedical health centres. The way these new laws took effect was not as expected by many adherents of traditional medicine. Since government now recognised traditional methods, many expected that doors would open for traditional healers to be able to access hospitals and other biomedical health centres and reach

out to patients already inside these biomedical health centres. They thought they might be able to offer their services as equals, in the same setting. Instead traditional methods are accepted on paper but in reality are shunned from the official perspective.

The Witchcraft Suppression Act 3 of 1957 was established to outlaw traditional healing which was used as the major means of healing linked to spiritually caused illnesses amongst African people. Its very name indicated a misconception about its nature, equating traditional healing with witchcraft, rather than its cure. The Act did not put an end to the utilisation of traditional healing methods. Instead, people still used traditional healing methods, but in secret. This was a clear indication that the government of the day regarded biomedical healing methods as superior. To this day constrained relations exist between those who use traditional healing methods and the biomedical practitioners and health workers, who generally frown on traditional practices. Some researchers' understanding is that when people begin to use traditional healing methods, they do it as a means of alleviating the "psychological stress" of the illness (Eastman, 2011, pp194-195). The reality could be that traditional people, literate and illiterate, who believe in the efficacy of traditional healing methods, do not view it as just alleviation of psychological stress, but the one means they have always known and relied upon for healing for hundreds of years. Long before biomedical healing was introduced in the colonial era, African people were healing themselves physically and not just psychologically with these means. In this context, 'literate people' simply refers to those who have acquired some degree of Western education and are assumed to have been acculturated.

Most literate people would not be confused regarding which healing method to use when faced with an illness. The nature of illness would indicate when to use traditional healing methods, when to use biomedical healing methods and when to use a pluralistic approach. They would be clear that traditional healing methods are indicated when the illness is perceived as spiritually caused. In other cases they may consult with biomedical health practitioners, but where treatment fails to work, they would suspect an evil spirit. Thus in some cases an illness which is thought of as starting out as 'naturalistic' could end up being accompanied by the acts of opportunistic evil spirits. It becomes difficult to compare the two since they operate from such entirely different worldviews. Early attempts by the South African government to try and get traditional healers and biomedical practitioners to work together were unsuccessful, largely because of the dominant position assumed to rightfully belong to the biomedical system. Eastman (2011, p196) asserted that:

> With their eminent status in their home communities, traditional healers were unprepared to function as entry-level primary health care workers, whose sole task was to supervise patients on behalf of the biomedical system. Equally, there was suspicion from many practitioners in the biomedical realm, whereby they would view traditional healers as remnants of the distant past, unskilled in diagnosis and readily prescribing remedies for which there was no scientifically ascertained basis.

Similarly, Levine (2012, p66) asserts that the practices of traditional healers are viewed as "dangerous and irrational" from the biomedical perspective. Hence people continue with the secret application of traditional healing methods where they view it to be necessary. This in itself is an indication that "cultural hegemony and ethnocide" has not been entirely successful.

At Ntsimbini location of Port St Johns Local Municipality (PSJLM), an interview was held with a 73-year old grandmother by the name of MaLungisile*. She was literate and still very active, healthy and energetic. She mentioned her grandchild's illness from *imasisi* (measles) and opted to take the child to the hospital for examination and healing. Surprisingly enough, after the doctor completed his examination of all the children including her sick grandchild, MaLungisile* decided to take out a bottle of traditional medicine for *ukuhanjwa* and gave the medicine as a drink to all the babies after the biomedical physician had left them, making sure that no one working for the hospital saw her in the act. Her rationalisation for this was that:

> *Wathi (ugqirha) ukuba asingele, ndathi kuba ndandiliphethe iyeza lesintu lorheqo, ndaseza owam ndagqiba ndaselisa bonke abantwana ababefole apho esibhedlele kunye nomzukulwana wam kuba ndisithi nangokufola into engapheliyo oku bangade barheqwe*.
>
> As soon as he (the physician) turned his back, because I was carrying the *ukuhanjwa* medicine with me, I gave the medicine to all the babies who were together with my grandchild at the hospital as I thought that by waiting to be attended for a long time they could end up being attacked by *ukuhanjwa*.

This is also an indication that the process of globalisation has not successfully eradicated the pluralistic approach in the field of illness, healing and medicine as suggested by Gangadharan and Shankar (2007, pp181-184). Where people continue with "dual health care seeking behaviour" (Eastman, 2011, 192) or the pluralistic approach, they do so in the belief that the one will address the spiritual component and the other will address the physical component. Since each society, including the West, has its own "culture of medicine or ethnomedicine" (Quinlan, 2011, p381), it is not surprising to realize that they are alien to each other and that people

favouring each one tend to become ethnocentric about them. Each will require translation and explanation by the emic person in order for the etic individual to have a better understanding.

Browner *et al*. (1988, p681)) in Quinlan (2011, p381) proposed a way to "combine the emic perspective of ethnomedicine with the etic measures of bioscience". They suggested the "identification of a health problem and how it is conceivably healed according to the locals, objectively assess the remedy's ability to produce the emically desired effect, as well as identification of areas of convergence and divergence between the emic and the etic assessments". In the case of mild *ukuhanjwa*, Browner *et al*'s (1988) approach would not work, as the illness is regarded with the utmost seriousness and urgent action is seen as key. The caregiver would not have time to wait for the outsider to observe the symptoms of the illness before applying traditional medicine – speed is of the essence. If caregiver is unable to identify the illness at its mild stage and it reaches the stage of severe *ukuhanjwa*, traditional people may involve the biomedical healing centre as a result of panic. In such cases, the biomedical practitioner could at least encourage the caregiver to give her emic description of the symptoms in order to identify points of commonality, and administer relevant healing medicines or methods. There should be no reason for biomedical health centres to verbally dismiss the existence of the illness, particularly if dismissal is based on the emic naming and aetiology of the illness. These things need have no bearing on their healing of the illness. If the etic person took the view that differences in language and worldview account for differences in naming and explaining the illness, a quite different outcome may result. Instead the dismissal frequently experienced by villagers is taken as an insult to their intelligence and thinking. If the more sensitive approach were used, local people could commend the biomedical health centres for

being able to heal their *abantu* illnesses, and insinuations of inferiority could be avoided. The two biomedical practitioners who were recognised for having the ability to deal with *abantu* illnesses showed that it can be done. They took an interest in the people's language and behaviours and took time to interpret them from the emic point of view.

If the intention of the biomedical health sector is to convert people from traditional healing methods to a whole new worldview, so that all change and begin using use biomedical healing methods exclusively, they would need to start with a radical programme of construction, building hospitals in every community, rather than expecting people to walk two hours or more from their homes to the nearest hospital, as stated by Ngqila (2002) with regard to Tafeni location, in Ngqeleni in the Eastern Cape. This would allow people to become accustomed to the biomedical healing system and its processes and procedures, and tensions between the two systems may reduce gradually. In such a case, and depending of course on the success rate of such hospitals, people might find that eventually the biomedical system becomes their first option. It is unlikely, however, that there would be complete abandonment of traditional healing methods. Acculturation would take place to some extent, but the belief in spiritually-caused illness cannot be removed, just as an entire culture cannot be removed. It may never be logical, from the biomedical perspective, to choose traditional healing over biomedical healing, but, as Quinlan (2011, p383) observed, "Each system has its own internal logic" which cannot be understood by the outsider.

In support of the idea of "internal logic" for each healing system, Quinlan (2011, p396) suggests that it would be fair to conduct clinical drug trials by comparing results of "patients using the

tested drug against the results of patients taking a placebo, rather than compare taking the tested drug with taking nothing" at all. Furthermore, Pushpangadan and George (2010, p12) have also supported the assertion by Quinlan (2011, p396) stating that it would be unfair to expect that the efficacy of traditional healing should be tested and measured the same way as the biomedical health system as these systems operate from different premises and with different strategies in mind. Biomedicine intends to eliminate germs, and the traditional system intends to expel evil spirits. Hence the majority of the participants in this study openly wished for the government to allow the two healing methods to operate at equal levels officially, with a policy in place ensuring the place of both. One would be seen as for physical healing and the other, for spiritual healing. One participant, Nonyange*, insisted that:

> *Xa kunokuthiwa masisebenzise amayeza esilungu kuphela, kungabe kuthiwa masife kaloku ngoba elona yeza lisebenzayo leli lesintu. Nalapho kulo mzamo wabo wokusohlukanisa namayeza esintu, bayohluleka, ngoba siyawasebenzisa emakhaya bengasiboni futhi sifike esibhedlele sibe msulwa, singatsho ukuba siyawasebenzisa ngoba siyazi ukuba abawafuni. Bade baxoke oonesi bezama ukusoyikisa bathi ayavela amayeza esintu apha kwidrip xa beyifaka ukuba uwasebenzisile. Bubuxoki obo, awaveli amayeza esintu xa uwasebenzisile*.
>
> If it were insisted that we should only use biomedicine and biomedical healing methods, that would mean they want us to die because the only medicine which works is the traditional medicine. Even with their attempt to stop us from using traditional medicine, they fail, because we use them at our homes without them seeing us such that by the time we arrive at the hospital, we appear innocent, we do not tell that we use them because we know that they do not want them. The nurses would even lie, trying to frighten us stating

that traditional medicine shows in the drip when they are inserting it if you have used them. That is a lie, they do not show when you have used them.

Nonyange* was a diviner aged 80, who experienced illness and was admitted to hospital for a few days, where she died about two weeks after the interview. She viewed traditional medicine as the only medicine which could holistically heal a person both physically and spiritually. She stated that illness could begin by being mostly physical but might end up opening a gap for the opportunistic evil spirits to take over whilst the patient was weak. Hence she insisted that traditional healing methods could never be marginalised. The biomedical sector, supported by the government has the opposite intention – that of persuading people to use biomedical healing methods exclusively, at least for a certain period, so that doctors can assess what works and what does not. It has been realised that it is extremely difficult to assess which healing method has worked in the case where both methods are used simultaneously. This is why Quinlan (2011, p396) says that there is a need to test the relative efficacy of traditional and biomedical healing methods by having one method used for one patient and the other method used for another patient, both suffering from the same illness, rather than testing the efficacy of biomedical healing methods against using nothing at all.

6.3.3. Influence of poverty on help seeking

The common misconception that people use traditional healing methods because of poverty, illiteracy and geographical isolation in rural areas is not supported by the research for this study. The reality is that a preference for African cultural methods of healing cuts across class and educational divisions. Many of those who live in urban areas have attained a high level of

education and are considered the "elite" of society but have continued to retain a strong belief in the efficacy of traditional healing methods. Enculturation is clearly a strong factor, for before people become acculturated to urban and Western ways, they absorb their mother culture. Belief in a spiritual realm and in the work of those who co-operate with or manipulate this realm, whether for good or for evil, seems unshakeable. The fundamental belief amongst many Southern *Nguni* people is that ancestors play a vital role in the lives of those they leave behind. Coupled with this is the idea that the ancestors are able to withdraw their protection and that when they do, misfortune and illness follow. This may be as a result of the actions of witches, who have the power to manipulate spiritual entities and create havoc in people's lives.

We see that cultural theories on illness, healing and medicine prevail among the acculturated and the enculturated, amongst Western people, literate and illiterate people, urban and rural people Vuyelwa*, the elderly woman who cured herself using sweet potato leaves, was a case in point. When her daughter's child became afflicted with *ukuhanjwa,* Vuyelwa* administered the traditional plants. The child's mother still insisted on taking him to the clinic for confirmation, despite Vuyelwa*'s assurance that the nurses would find the child healed:

> *Ndamxelela ukuba amanesi aya kumfumana ephilile umntwana futhi aya kusuka axakwe nje ukuba ebemsaphi umntwana e*clinic *kwaye kunjalonje, kwaba njalo kanye*.
>
> I told her that the nurses were going to find the child healed and were not going to understand why she brought the child to the clinic and indeed, that is how it happened.

This was an indication of embedded traditional beliefs which could not be shaken.

These traditional methods of healing, called theological or metaphysical by those who subscribe to the biomedical pattern of thought, have not been tested in a way that would satisfy the requirements of the biomedical world. Clearly there is some room for further research here. The evidence that they work, however, seems to be sufficient to keep many people, both poor and well-off, adhering to them.

6.4. The Southern *Nguni* contextual meaning of 'invisibility' of *ukuhanjwa* to the biomedical health system

Ukuhanjwa, as has already been explained in previous chapters, is one of many *abantu* illnesses which are sometimes referred to as *ukufa kwabantu*. According to Liebeck and Pollard (1995, p897), visibility refers to being able to be seen or noticed. Applying the term "invisible" to the symptoms of *ukuhanjwa* could be confusing to the outsider as the symptoms are clearly visible. But the term refers to the whole condition, not only to its symptoms – its causes are included in the term.

The biomedical interpretation of the condition varies but includes the suspicion of sexual assault, nappy rash and diarrhoea. The loss of muscle strength in the neck and the sunken fontanel are seen as results of severe dehydration.

Although believers in traditional healing recognise all the symptoms as typical of the illness, as outlined in chapter 4, the first point of check and the clearest indication of *ukuhanjwa* is the wide open anus. There are cases where the wide open anus is thought to be "hidden". The condition is present but the familiar has managed to hide the evidence. If this is the case, it would be very

easy for the victim to reach the stage of severe *ukuhanjwa* without anyone noticing, placing the life of the victim at risk. When a caregiver takes a child suffering from *ukuhanjwa* to a biomedical centre, she is faced with problems immediately as the tendency would be for a biomedical practitioner to separate the cause from the symptoms and see little correlation between the symptoms. The caregiver would be left feeling dissatisfied with the explanation rendered by the biomedical health sector on the illness causation and method of healing they are going to receive. Sometimes the victim or the caregiver would just mention the name of the illness, *ukuhanjwa,* to the biomedical nurse or practitioner without giving a full description of the symptoms. The biomedical practitioner would find the name meaningless as it is not a recognised condition.

In traditional healing, purity, too, is something that is present but not seen. All traditional healing methods which deal with spirituality and spiritually-caused illnesses are believed to be ritually pure with the ability to ritually purify the ill or polluted person or prevent pollution before it occurs. This is one of the reasons why people who believe in *ukuhanjwa* cannot easily give up their methods – ritual purity is of fundamental importance to them. The very strong smell and taste of traditional medicines used for healing *ukuhanjwa* are believed to be evidence of their ritual purity. It is the taste and smell which contain the power to ward off pollution and to prevent familiars from further polluting the same victim until the process of healing has been successfully achieved.

NoLungisile* noted that:

> *Umguli akacinyelwa ukuba makahambise koko ucinyelwa ukuba iyeza lihlale apha ngaphakathi kuye limsebenze likhuphe ukungcola kunye nobushushu*.

The ill person would not be given the medicine for purging but for it to remain inside, for cleansing the dirt from the inside to the outside in order to 'cool' the ill.

According to the Southern *Nguni* people, the contextual meaning of *ukungcola* (dirt) and *ubushushu* (heat) is pollution. They are the tracks (*umkhondo*) or traces which are left by the penetration of the familiars, and they require ritual purification for cleansing in order to achieve successful healing. The bitter and biting taste of the traditional medicines used for the illness in question is believed to have the ability to magically squeeze out pollution from the inflicted parts of the body by means of 'sympathetic magic', with the result that bodily openings return to their original size, before they were harmed and deformed.

6.5. Pluralistic tendencies in healing *ukuhanjwa*

A research report by Ross (2010, p46) which stated that for every ten black people, eight use traditional medicine alone or in combination with biomedicine was confirmed in this study as true for the Southern *Nguni* people of ORTDM. A strong factor influencing the pluralistic nature of help seeking is that people wish to avoid the accusation of not having really tried to find a cure. Since illness is viewed holistically, as spiritual as well as physical, all avenues must be tried.

Another reason mentioned by Eastman (2011, p184) was that traditional healers are more easily and widely available as an integral part of the population's social and cultural system. This might not be true for the Southern *Nguni* people of ORTDM as their behaviour is influenced by their belief system far more than the availability or non-availability of both medical systems. Many

urban people, it has been pointed out, will travel for miles to find the right diviner. And many of these same people live in close proximity to biomedical centres.

These pluralistic tendencies are influenced by the belief that healing is not just about the physical body only, but also about spiritual healing – hence, for the Southern *Nguni* people of ORTDM, the belief system is the chief factor in deciding where to seek help. As, Kleinman (2010, p86) says, different medical systems employ different explanatory models in an attempt to make sense of disease and give meaning to the individual and social experience of illness. Thus many people will explore all options at their disposal so as to minimize the blame for ill health or death, since, for them, illness and health are defined holistically.

Another reason for the pluralistic tendency in healing is that what is perceived as illness in one culture may not be perceived the same way in another culture. Witchcraft is not recognized in the biomedical health system while for traditional people it is a reality – hence traditional people are open to all options for healing at their disposal.

Eastman (2011, p184) confirms that traditional healing together with biomedical healing is widely practiced across social boundaries, as it is "not confined to a particular generation or even socio-economic standing". One notices a particular pattern amongst urban people who are assumed to be acculturated. They begin with the biomedical means of healing and later resort to traditional healing methods. Some would immediately engage with both. Their reason for doing this would be their belief that even if the illness starts by being physical, evil spirits or familiars are opportunistic and will attack the victim when he is weakest, so that the ill person confuses

spiritual with physical illness. This has also been realized by Farrand (1984, p2) and Shoko (2011, p290) although Shoko went on to mention that this pluralistic nature of healing is not only prominent with the urban black people but is also found in the rural areas.

Thinwa (2004) noticed the same pattern with urban Tuberculosis (TB) and HIV/AIDS patients, where about 70% adopt a pluralist approach, in an attempt to overcome their fear and recover as quickly as possible. With the strongly enculturated, there is no noticeable pattern or order of use; some would opt for biomedical healing first and immediately after that consult with the traditional healer; others would reverse this order or leave out the biomedical system altogether. When people opt for biomedical healing first, they do so generally do avoid the blame they are likely to experience at hospitals when they have delayed coming. They get started on biomedicine, then turn to what they feel will really cure them – traditional methods - and if that doesn't work, they can return to biomedical medicines and avoid being accused of presenting with an illness when it is already advanced. Zanemvula*, a traditional healer who was a herbalist (*ixhwele*) at Qokolweni, KSDLM, revealed his approach in healing:

> *Amaxesha amaninzi ndiye ndimbuze umntu ukuba ngaba ebesiwe na kwagqirha phambi kokuba ndimsebenze ngoba amaxesha amaninzi ndidla ngokufuna ukuba umntu ancame kwagqirha ze ndimsebenze ke. Azange ndive kusithiwa ukudliwa kunyangiwe ngoogqirha besilungu*.
>
> Most of the time I ask a person whether he or she has been taken to hospital before I begin to work on the person because most of the time I usually want a person to try the biomedical practitioner so that I work on him or her then. I have never head of *ukudliwa* illness healed by biomedical practitioners.

Those who opt for traditional healing first do so for the same reasons that biomedical practitioners insist that Western doctors and hospitals should be the first choice; in order to avoid an escalation of the illness. Those who are caregivers want to avoid being blamed for not seeking help. Nozukile* insisted that:

> *Asali ukuba abantu mababase eclinic abantwana kodwa kwsei sigulo siqala simkhamele umntwana phambi kokuba aye kulo clinic, futhi naxa ebuya asimyeki ukumkhamela xa kubonakala ukuba sele imongamele. Kodwa amaxesha amaninzi umntwana eli yeza ulifakwa isihlandlo sibe sinye aphile ngoko nangoko*.
>
> We do not prevent people from taking their children to the clinic but with this illness we first give traditional medicine to the child before he or she goes to that clinic, still even when the child is back we do not stop giving the traditional medicine when it is evident that the illness has escalated to a serious stage. But most of the time the traditional medicine would be administered once and the child would be healed there and then.

For such people biomedical methods would be their second choice. Bhana (1986, p221) had a similar encounter with Indians who had the same practice of seeking help from both biomedical centres and traditional healers, especially for mental illnesses. The Chinese have established that the same illness can be healed using different methods of healing (Hu, Du, Shen and Xu, 2012, p2). Thus the pluralistic tendencies around healing are common and widespread.

6.6. Linking the source of the healing power with the continued use of traditional healing methods for *ukuhanjwa*

It has been discussed in chapter 5 that there are specific factors which contribute towards the trust and belief that Southern *Nguni* people have in the power of traditional healing for *ukuhanjwa*. These factors include the person who has recommended the traditional healing method, the bitter and biting taste of the medicinal plants, the very strong smell of the plants and the level of faith and belief that the caregiver has in the methods used.

Researchers have come to a variety of conclusions in relation to the continued use of traditional healing methods. Some of these are refuted by the outcomes of this research amongst the Southern *Nguni* people of ORTDM. These conclusions include the opening hours of service for traditional healers, whose constant availability is thought to contribute to the loyalty people have for them (Friend-du Preez, Cameron and Griffiths (2009, p345), Truter (2007, p60) and Ross (2010, p47)). Research for this study suggests that the loyalty people have towards traditional healers and methods has little to do with opening hours, and far more to do with the power of belief, enculturation and conviction about the realities of the spiritual world. Biomedical centres are seen as just not equipped to deal with the full nature of sickness. Siziwe* elaborated more on this:

> *Nasesibhedlele baye bathi umntwana xa sele ebaxakile ufike sebebuza ukuba, "Ubumseze ntoni? Hamba umse kule ndawo ubumqalise kuyo ke." Baxakiwe ke oonkabi nabo, ntonayo benqena ukutsho ukuba bohlulekile. Kodwa ke asinokwazi ukuthetha gabalala ngamayeza ethu kwabezempilo ngoba bangasithuka ngaloo mayeza ethu. Yiloo nto ke siphetha siwasebenzisela emfihlakalweni*.

> Even at the hospitals, when they are unable to heal the child and not knowing what to do, they would begin to ask questions such as, "What medicine did you give to the child? Take the child to the place where you started before bringing the child to us." That would be a sign indicating that they are also stuck but will not admit to having given up. But we cannot speak openly about our traditional healing methods to the biomedical health workers and practitioners because they would insult us about using our traditional medicines. Those are some of the reasons which cause us to use traditional medicine secretly.

Traditional people have been given the impression that biomedical healing methods are superior and to traditional people, 'superior' means having absolute success in every performance. They are not familiar with the idea that even biomedical healing methods may fail, and that many treatments do not work perfectly the first time. When something that is touted as superior fails to work the first time, they do not think of requesting an adjustment to the dosage, or a different approach. They conclude that the disease is beyond the abilities of the biomedical centre – in effect, invisible to practitioners. It would appear that the idea of trying, adjusting, co-operating with the doctor to observe changes and improvements is not something that has been explained to people. Perhaps it is a mark of the hegemonic tendency of the biomedical health system that in their determination to win the battle against traditional practices, they too assume that their methods will work perfectly and do not consider that healing is sometimes a process, requiring trial and error in some cases.

Friend-du Preez, Cameron and Griffiths (2009, p345), Truter (2007, p60) and Ross (2010, p47)) have also mentioned the issue of staff and drug shortages in biomedical health centres. The

outcomes of this research have indicated that neither shortages of drugs nor of staff are of chief significance, but what is of most significance is the Southern *Nguni* belief in the invisibility of cultural illnesses to biomedicine.

This brings the discussion back to the link between the perceived source of the healing power and the continued use of traditional healing methods for *ukuhanjwa*. The continued use of these methods has everything to do with the level of belief and faith that caregivers have in the efficacy of these healing methods. In support of the statement, Zakhele* said that:

> *Oomama ndibabona bekholelwa kakhulu kula mayeza orheqo ngoba bathi ayasebenza. Nam ke ndiye ndimbone ephila umntwana emva kokuba enyangwe ngala mayeza. Unkosikazi wakuthi uyawazi amayeza, wawafundiswa ngumakazi nomama wakhe - ukhulele kuwo amayeza, yiloo nto ewasebenzisa nam ndiwabone esebenza*.
>
> Mothers strongly believe in these traditional medicines for *urheqo* illness because they say they are working. Even myself I have observed and witnessed the healing of the child after being treated with these traditional medicines. My wife has vast knowledge about traditional medicines, she was taught by her aunt and mother – she grew up using traditional medicine, hence she has continued to use them and I have also observed them working.

Zakhele* concurred with Zanemvula* regarding the above argument stating that:

> *Azange ndikhe ndive kusithiwa umntwana onokuhanjwa usiwe kwagqirha okanye esibhedlele. Uhlala enyangwa ngesintu*.

I have never heard of a child with *ukuhanjwa* taken to the biomedical practitioner or hospital. She or he has always been healed using traditional medicine.

Siziwe* concurred with the above assertion by Zakhele* and Zanemvula*, mentioning that:

Esibhedlele simsa nje ukuba kuthiwe simsile hayi ngoba sikholelwa kuncedo lwabo. Sikholelwa kumayeza esintu xa sinyanga esi sigulo. Kanti namanesi aye aphume akhe amahlamvu amkhamele ngokufihlakeleyo esiyala ukuba singatsho kugqirha ukuba umntwana ukhe wakhanyelwa – lawo ngamanesi anolwazi ngesi sigulo.

We only take the victim to the hospital so that they would not view us as deviants, not because we believe and trust their help. We believe in traditional medicine in healing this illness. Even the biomedical nurses would go out and pick some leaves to make traditional medicine and apply it to the victim cautioning us not to tell the doctor that the child has been given traditional medicine – those are nurses who have knowledge about this illness.

Incidents such as these, where people who may be expected to subscribe to biomedical values and methods appear to support traditional practices, strengthen the level of belief amongst traditional people in their traditional health system. Traditional people have always preferred traditional healing method for *ukuhanjwa*, not solely because they have not received good medicine from the biomedical health centres, but because their belief is that the illness requires immediate attention and involves evil spirits requiring spiritual healing methods. In the rare case where traditional medicine has not worked, slowness to act would be blamed. It is extremely difficult to find someone who has used only biomedical healing methods for *ukuhanjwa*. It has been emphasised by MaLungisile* that:

Uyafa umntwana wale nto, yiloo nto kufuneka akhawulezelwe xa ethe wabonwa. Kuba kubi xa ebonwe kade ingakumbi xa edliwe efokothweni.

Death is highly possible for a child who has this illness – hence the need for an immediate response when it is noticed earlier. It becomes an ugly situation when noticed very late especially when attacked on the fontanel.

Time and again, the participants in this study asserted their absolute loyalty to traditional methods. As Zakhele* said,

:

Noba bathi masiwayeke amayeza esintu bayadlala ngoba abazusilandela baye emakhayeni ethu apho siwasebenzisa khona. Kwa-isigulo esi sokuphambana kunye namafufunyane abakwazi ukuzinyanga oogqirha besilungu. Kanti isintu sitsho kuqala simnyange ngokupheleleyo umntu.

Even if they say we should stop using traditional medicine they are just joking because they are not going to follow us to our homes where we use these traditional medicines. Biomedical practitioners are unable to heal even mental illnesses and spirit possession illnesses. But with traditional medicine and traditional healing methods the ill person would be healed immediately and completely.

It is important to note however that belief and faith alone would not have been enough to convince traditional people to continue with the use of traditional medicines. There has to have been evidence of healing with these methods. Zakhele*, in support of Vuyelwa*'s view, concurred with the rest of other participants who believed in the efficacy of traditional healing

methods for *ukuhanjwa* up to a point that he stated that he would proudly recommend use of these traditional healing methods:

> *Ndingakukhuthaza kakhulu ukusetyenziswa kwamayeza esintu okunyanga isigulo sokuhanjwa kuba ahlala esebenza amaxesha ngamaxesha ekugxotheni umoya omdaka ukuze umntwana aphile*.
>
> I would highly recommend the use of traditional medicine for *ukuhanjwa* because it has always worked, many times, in chasing away the evil spirit for the baby to recover.

Thus the faith and loyalty that people show towards the traditional methods of healing for *ukuhanjwa* are backed up by a success rate that cannot be disputed – when it is caught early enough. The fear and alarm that this disease engenders is related to the fact that when noticed and acted upon too late, it invariably leads to death. That is why traditional Southern *Nguni* mothers always check the anus of their children when a child exhibits unusual sleepiness. Nokholo emphasised that mothers should always be alert:

> *Kubalulekile ukuba umama womntwana ahlale emkroba umntwana ingakumbi xa enomkhuhlane*.
>
> It is important for the child's mother to always check the child's anus especially when experiencing fever.

Familiars, which are known to be responsible for *ukuhanjwa*, are believed to be opportunistic, attacking victims who are already weakened, so that any simple illness may be an opportunity for *ukuhanjwa* to take effect. Hence the high caution amongst Southern *Nguni* mothers regarding what they believe to be a threat to the health of their children. Their belief and faith in the

efficacy of the healing methods for *ukuhanjwa* is enhanced when the person who recommends the cure – or who recommended it to one's mother or other relative - has a history of positive cures, is trusted and a well-known diviner with an excellent track record. The spiritual power contained in the plant, as ordained by God and revealed initially by the ancestors, also play their part in making these methods the trusted and apparently successful method which they are. So too does the bitter and biting taste of the plants. These are felt to owe their power to 'sympathetic magic' by which body openings are shrunk back to their original size. Along with taste, the smell is believed to chase away the familiars or evil spirits until the victim has completely recovered as a result of 'sympathetic magic'. The belief is that if the smell is strong enough to affect human beings, then 'sympathetic magic' would make it possible for the familiars to be strongly affected by the smell too. In simple terms, the Southern *Nguni* people link the source of the healing power of traditional healing methods for *ukuhanjwa* to the following factors:

- The natural magical and spiritual power in the medicinal plants embedded in the bitter taste and strong smell of the plants, which work by 'sympathetic magic'.

- Trust, belief and faith in the efficacy of the healing method and of the person recommending the healing method based on the positive experiences that person has had with healing, be it an ordinary person, an herbalist or even a diviner.

- Ritual timing linked to the application of the healing method for it to work successfully to prevent escalation of the illness to the worst condition.

- Ritual space linked to the maintenance of the healing power in the traditional medicinal plants as well as ritual space linked to privacy needed by the male owner of the familiar (*ichanti* snake) with the victim for efficacy of the healing method for *ukuhanjwa*.

The above four sources have contributed mostly to the strong faith that the Southern *Nguni* have in the healing methods of *ukuhanjwa.* They would not have attempted to use them if the above four sources were lacking. But from an outsider's point of view, one could conclude that continued use of these methods may be attributed to their efficacy and not merely to belief and faith.

6.7. Summary of the chapter

The various interpretations and meanings attached to illnesses, health and medicine by different cultural groups are associated with various positions of power or lack of it. Belief in a spiritual world and its manifestations in health and illness are generally assumed, by those who hold political and economic power, to spring from less well-developed cultures. The manner in which people conceptualise illnesses and illness causations determined and still continues to determine how they deal with illness and disease. The various approaches are culturally embedded and have less to do with history and development than with enculturation. Resistance traditionalism is a manner in which people hold strongly to traditional healing methods despite living in an era of globalisation and rapid change.

The different responses of different cultural groups to issues of health could be what triggered the hegemonic tendencies in the biomedical health system, which is one amongst several cultural healing methods. Its hegemonic tendency is clear, and empowered by the support it receives from governments the world over. It tends to label the dominated forms of healing as inferior as part of a strategy to effect complete domination and bring about social change. The forces of

globalisation on illness, health and medicine, social and political processes and the influence of poverty are often cited as reasons for the hegemonic tendency of the biomedical health system.

The Southern *Nguni* contextual meaning of the 'invisibility' of *ukuhanjwa* to the biomedical health system, and their conviction that it is a spiritual attack leads them to insist on traditional healing methods for the illness. Where biomedicine is sought, it is used as part of a pluralistic approach. The strong belief in the efficacy of traditional healing methods for cultural illnesses such as *ukuhanjwa* appears to be as a result of the perceived source of their healing power. This faith in the source of the healing power enables traditional methods for this illness to withstand every attempt by biomedicine to undermine and counteract it.

Power relations and discourses existing in the field of illnesses and medicine are usually prompted by the language factor as well as the fact that no cultural group would submit to being made to feel inferior. Hence the traditional people tend to resist allowing extinction of their cultural practices by being placed in the past as history. Occasional failures of biomedical health centres to heal some of the illnesses have created loopholes which are used as reference by traditional people to justify their traditional healing methods. Their interpretation is that biomedical health centres fail to heal such illnesses because the illnesses are invisible to them and are cultural illnesses. These behaviurs and interpretations are all expresions of resistance to the hegemonic tendencies of the biomedical health system. In response, the biomedical health system insists that their hegemonic tendencies are for a good cause, namely the improvement of health, positive social change and ultimately the advancement of humanity.

The Southern *Nguni* people view witchcraft as an evidence-based theory, citing case studies of unexplainable illness and the confessions of witches as evidence. They are convinced that when a person confesses to acts of witchcraft, they have not lost their minds as psychologists and doctors claim, but are referring to real events. The fact that witches confess, people die where no prior condition exsisted, and that spiritually-based diagnoses and cures actually work are all taken as empirical evidence that witchcraft and its cures are real. The psychologists' contention that the confessions and the illnesses, together with evidence of successful healing, are all mere coincidence is not believed.

Another aspect of the evidence of witchcraft, to the traditional Southern *Nguni* person, is the fact that *ukuhanjwa* is accompanied by no pian. This seems unnatural, given the visible condition of the person and evidence enough that it is a cultural or *abantu* illness. The Southern *Nguni* people interviewed gave examples of illnesses they experienced without pain, and included *ukuhanjwa*. They specifically differentiated between different types of babies' cries, with a weary cry indicating tiredness or something spiritually amiss, and a loud cry indicating pain. The typically weary cry of the baby afflicted with *ukuhanjwa* could not be linke to physical tiredness, as the babies had slept long. Hence it was taken an indication of spiritual interference, in this case, *ukuhanjwa.*

Although the South African government lifted the apartheid laws against traditional healing, it seems as if the act is just on paper and not operational, according to the desires of traditionalists, who would like to see the operationalisation of an integrated health system of the traditional and biomedical health systems. What seems to be working for now is tolerance, with the biomedical

health system enjoying the favour of government and recognised as the official, authorised health system. The traditional health system is openly used by traditionalists, but remains in an inferior position, with government officials discouraging, though not outlawing, it's use. The incorporation of traditional healers into the peripheries of the health system has been done in such a way that it entrenches and underlines the inferior status of tradional healers.

Most Westerners assume that traditional healing methods are employed only by uneducated and poor rural people who have no access to biomedical health centres. The outcomes of this study have disproved that. Traditionalists who believe in the efficacy of traditional healing methods are found in urban and rural areas, and amongst the literate and illiterate, the poor and the elite. The same applies when it comes to the pluralistic tendency in help seeking, which is common amongst both urban and rural people, literate and illiterate, poor and wealthy. The common practice for the wealthy and educated person is to start with biomedical healing methods and if that fails to effect a cure, to suspect the presence of opportunisitic evil spirits and and switch to traditional methods. Rural people and many urban people are known to use traditional and biomedical healing methods either simultaneously or alternatively, should either of them fail to work quite quickly.

It is the source of the healing power which has motivated traditional people to continue with the use of traditional healing methods for what they believe to be cultural illnesses. Four sources of healing power have been mentioned. The first one is God's signature in the bitter and biting taste and strong smell of the traditional medicinal plants. The second is their own faith and belief in the efficacy of the healing method and in the person - diviner, herbalist or elderly person – who

recommended the healing method. The third is ritual timing regarding the sourcing of plants and the application of the healing method. The fourth is the ritual space where the plants are picked for preparing traditional medicine, or the place where the male witch heals the person attacked by *ichanti*.

CHAPTER 7: CONCLUSION

7.1. Overview

This chapter concludes the dissertation by outlining the researcher's personal conclusions regarding the illness in question, as well as reviewing her overall experiences and impressions during the research period. The chapter also outlines some implications of the findings regarding the researcher herself, other researchers, the traditional community, and all stakeholders who have an interest in and responsibility for the welfare of the people studied. Implications of the study have also demonstrated how the point of discussion has not been on which system of healing is closest to the truth but to establish points of divergence and convergence in the different conceptual frameworks for illnesses. Implications of the study have also been presented such that an attempt has been made to bridge the gap between the different worldviews and to create better understanding of '*abantu'* illnesses in an era of globalisation.

7.2. Conclusions regarding the research findings

This conclusion is based on all the findings, and attempts to determine whether the research questions have been answered as anticipated, and whether the objectives of the study have been fulfilled. Many researchers have conducted research in related fields and come up with different findings and theories, and these have helped to give direction to the study. In some cases the findings of others are supported, and in some cases, refuted, but all research material has been found helpful.

It seems clear from the findings that a unique illness known to the Southern *Nguni* people of ORTDM exists, known as *ukuhanjwa* and identifiable by certain consistent characteristics. These are the wide open anus, red patches on the lips, around the outer lining of the anus and on the tip of the genitals, fatigue and a desire to sleep, with a distinctive weary-sounding cry in the case of infants. In advanced or severe *ukuhanjwa* there is also the sunken fontanel, the loss of muscle strength in the neck, white regurgitation of feeds (*uxakaxa*) and thick saliva through the mouth. Mild *ukuhanjwa* seems to attack the lower parts of the body, and severe *ukuhanjwa* includes these lower parts and the upper parts. In severe *ukuhanjwa*, caregivers report that the anus is so wide open that one is able to see right into the intestines, with a ring of red patches around the anus and genitals. There may be, at this stage, vomiting and diarrhoea, and pus emitting from the anus and nose. *Ukuhanjwa* can attack a person of any age but is usually found in babies. It is known to be fatal if left untreated.

The question is, "How did these symptoms originally lead to the diagnosis of *ukuhanjwa*?" The answer lies in the Southern *Nguni* worldview and conceptual foundation, which includes the high esteem in which diviners are held. Firstly, people trust diviners, who have the knowledge, it is believed, to commune with the spiritual world and to learn and know things which other people do not. Diviners who diagnosed the symptoms also healed the symptoms, and this was foundation enough to trust and to continue to follow their advice.

Lending credence to their own interpretation of the symptoms is the fact that biomedical practitioners were so often incorrect in their assumptions about the sickness. The apparently incorrect assumptions by biomedical practitioners, coupled with their reported inability to cure

the illness, is, to Southern *Nguni* people, evidence enough that the illness is not known or recognised by biomedicine, and must be cured the traditional way. It adds further confirmation that not only their cure but their aetiology for the illness is correct.

The question as to how *ukuhanjwa* came to be known and believed to be spiritual penetration is linked to the trust that people have in diviners. Before the introduction of biomedicine, traditional people relied solely on diviners and they trusted the information, diagnoses and cures they received. There was no need to question the diagnosis of *ukuhanjwa*. They were shown that the illness is a collective of symptoms, and all must be present for it to be *ukuhanjwa*. The first indication would be sleepiness. The child had to be sleepy and tired for long periods during the day, alerting the caregiver, and causing her to examine the anus. Without the tell-tale sleepiness, it would not be common for a caregiver to check a child's anus. This pattern of observation and checking has been the same ever since the first consultation regarding the illness in question, and the Southern *Nguni* have never stopped using those symptoms as their point of reference to identify and apprehend *ukuhanjwa* at its mild stage.

One of the most striking aspects of the illness is that, despite the fear which surrounds it and the seriousness of the sickness, the Southern *Nguni* have developed no particular strategy to pre-empt it. All responses are at the point of attack and immediately afterwards. No long term measures are adopted to prevent it from re-occurring. This seems to be chiefly because the illness is considered fairly rare, and strategies that would probably involve the daily application of a herbal concoction are deemed unnecessary. Also, the belief is that attack is not planned or willed by anyone, and cannot therefore be associated with enmity or a souring of relationships. It is a

totally random attack by a familiar which loiters about with nothing to do. Since the illness cannot be blamed on any person, people do not see a reason to be always alert. Apparently, it is not that there is no way of preventing occurrences of *ukuhanjwa*; indeed the same medicines used to cure it could be used to keep it away for the long term. The reality is that people forget, and do not feel a sense of urgency about preventative measures, particularly as these attacks are not common.

Regarding cures for *ukuhanjwa*, there are specific traditional remedies, and these seem to work perfectly well – at least in the case of mild *ukuhanjwa*. A teaspoon of a concoction made from *isivumbampunzi* (*Tulbaghia violacea*), or *iboza* (*Plectranthus barbatus*) is given as a drink to the victim, and droplets of the same concoction placed around all bodily openings. For severe *ukuhanjwa*, the Southern *Nguni* people take their guidance from the diviner. In this case it is always a concoction made from the boiled familiar which has attacked the victim. Familiars associated with female witches are the mouse (*impaka*), and the puff adder (*irhamba).* As mentioned before, the mouse described seems to fall somewhere between two common South African mice, *Graphiurus murinus* (woodland dormouse) and *Elephantulus edwardii* (Cape ink Sengi).

In cases where the attack is by *ichanti*, the familiar used by male witches, a special ritual known only to the male owner of this snake needs to be performed. Usually the owner gets to hear of the illness and comes forward voluntarily to offer to heal the child. But the healing has to be performed privately in the presence of the male owner of the familiar and the *ukuhanjwa* victim and in the absence of the caregiver. The involvement of the male owner of the familiar is only at

the severe stage of *ukuhanjwa*. When mild *ukuhanjwa* has escalated to the level of severe *ukuhanjwa*, the diviner would also be involved. Chances for survival at the level of severe *ukuhanjwa* have been less than 50%. as out of three participants only a had a child who had been successfully healed.

Southern *Nguni* people are very specific about the ritual space and time of day for harvesting the medicinal plants. They need to be ritually pure and have the required, maximum healing power, and for this, the place and time for collecting the herbs must be revealed to the diviner by his or her ancestors, through dreams. The same applies for any person who happens to be treating the ill person. The person performing the healing needs to highly aware of the significance of ritual purity, expressed through the place and time that the plants are collected.

In addition, the time and place where the medicines are prepared is also specific. In the case of severe *ukuhanjwa* caused by *ichanti*, the male witch is always very particular about the ritual space where he is to perform his ritual healing. Only the victim and not his or her mother or caregiver may be present. Ritual timing, too, is very important. It has always been emphasised that an immediate response to the illness is vital for successful healing and even a slight delay can result in severe *ukuhanjwa*. This issue of timing is one of the chief factors why biomedical healing cannot be considered. It would take too long to get to hospitals, whether the person is in a rural or an urban setting – even a lapse of hours can be fatal. An immediate response, according to the Southern *Nguni* people, becomes a requirement and a priority, whether the caregiver intends to cure the victim herself, or whether she intends to consult with a diviner. The whole

healing process of *ukuhanjwa* ends up being ritualised, and no one has ever wanted to deviate from the stipulations that already exist for curing this illness.

Regarding the source of the healing power for curing *ukuhanjwa*, the belief is that the magical and spiritual power of the traditional medicinal plants lies in their bitter, sharp taste and the strong smell of the plants. Ultimately, they derive their power from God, and this is recognised and stated. The qualities of smell and taste are believed to work by 'sympathetic magic', as explained in chapter 5 and 6. It would cause the victim to smell like the familiar so that when the familiar revisits it would become confused, thinking that the victim is one of them, and be repelled. Other sources of the healing power lie in the aspect of ritual; the manner in which the medicinal plant is revealed to the diviner, the diviner himself, and the space where the plants are gathered. It cannot, for instance, be a domestic setting. These plants cannot be cultivated. The appropriate ritual space for gathering the plants is the open fields outside the homestead. The belief is that if these plants are cultivated at home, a familiar may walk over them and by so doing, take away the healing power of those plants. Hence it is necessary to pick the plants outside the homestead to ensure that they contain maximum healing power. Ritual timing also matters as another source of the healing power. The diviner must be well known and have a record of healing successfully, and he should be guided as to where to find the plants by his ancestors. All of these factors play into the trust that people have in the power of the cure. It is indeed a ritualised process, with set ways of doing things, which are not deviated from.

Southern *Nguni* people believe deeply in the existence of witchcraft as an evidence-based theory, and made efforts during interviews to present evidence for their belief. The confessions of witches which many people had anecdotes of, are proof enough for most people.

The pluralistic approach has always been used for severe *ukuhanjwa* – people will start with traditional healing methods at home, followed by a visit to the hospital, usually just for record purposes. Later they will return to the traditional healer. This would be the case especially where the traditional healer has not had great success. People want it on record that they went to the hospital early. They may not place much faith in the hospital, but in the state of emotional turmoil in which caregivers usually are at this stage, anything will be tried. If the child is to die, it must be shown that the caregiver took the child to the hospital, so that no blame would ensue.

The hegemonic tendency of the biomedical health system is strengthened by the support this system gets from the South African government politically and economically. The assumption by the biomedical world and the government seems to be that biomedical healing is the final word on health and healing, and that this system will rightly overpower and eradicate all other practices in the end. Indeed it is more than an assumption; it is an intention, as medical care is a means through which government can effect social change. Social change has never been easy to control; cultures modernise in their own way, as pointed out in the theory of cultural modernity.

The resistance that the biomedical system experiences in its drive to conquer minds may be partly as a result of its tendency to portray itself as the 'know it all' health system. It promotes

the idea that it is superior, and holds all the answers. This poses difficulties and causes confusion amongst traditional people, when it clearly cannot deliver on its claims.

As has been mentioned, traditional people believe that even illnesses which start out as merely naturalistic may develop a spiritual component as a result of the actions of opportunistic spirits, who attack and disguise themselves in the cloak of the physical illness. Either they attack opportunistically, or they have been there all along as a result of the will of a witch. Either way, the biomedical world will not recognise and deal with this aspect of the illness; it is invisible to them, and hence their attempts to cure are doomed to fail. As a result, Southern *Nguni* people insist on the continued use of their traditional healing methods. Their adherence to traditional cures is so entrenched and resilient that it may be thought of as a form of resistance to biomedical hegemony and indeed to cultural imperialism. The power entrenched in the biomedical world is undermined by the beliefs of people who have found that Western modernity's cultural interpretations of illness clash with their own. Thus the hope of bringing about social change through a unified health care system has not met with complete co-operation. This takes the discussion back to the fact of differing experiences and interpretations of illnesses based on culture and worldview.

The concept of cultural congruency has been much discussed amongst academics and some moves in the direction of establishing parity for traditional healing were made with the formation of the Association of Traditional Healers in South Africa. On the whole, however, traditional healing is still viewed as the inferior sibling to biomedicine, necessary only to placate the traditional sector of the electorate. For Southern *Nguni* people, cultural congruency would mean

the recognition of traditional healing methods as an additional and equal aspect of national health care. Such a system might be possible, if modelled along the lines of the Indian and Chinese models, where the traditional and biomedical systems are not seen as being in conflict, and where traditional healing is held in higher esteem than in South Africa. Instead we seem to have adapted a model closer to the British and German models instituted during colonial days, where traditional healing is looked down upon. Though not out rightly banned as was the case during the apartheid era, patients are constantly confronted with negative perceptions of traditional healing when interacting with biomedical centres. The system flourishes, with traditional remedies sold openly on the streets of towns such as Mthatha, but must be engaged in privately, with patients left to make up their own minds as to how these remedies will co-exist with biomedicine. The risks of mixing medicines from the two systems remain unknown.

For this study, various theoretical frameworks revealed through a study of the literature were used as hypotheses. In some cases, hypotheses were confirmed; in other, they were refuted. Attribution theory can be said to have been confirmed. The findings also confirm that social constructionism is a relevant and appropriate theory. The findings have also confirmed the cultural theory of modernities in the sense that the Southern *Nguni* people have demonstrated how much they believe in their illness and healing theories, despite their being old. The cultural theory applies more to urban people who are assumed to be acculturated and modernised, and are expected to behave and think in an urbanised manner. It turns out that there is a strong strain of traditionalism in urban Southern *Nguni* people, even amongst those who are highly educated. When it comes to *ukuhanjwa*, traditional thinking prevails. Lastly, the functionalist theory has been used for the conceptual framework on *ukuhanjwa* by the Southern Nguni people of

ORTDM and a way of responding to the assumptions of the researcher regarding what influences responses of the people to the illness in question.

The pluralistic tendency in healing illnesses has been found to be a common practice across all people, rural and urban, literate and illiterate, acculturated and enculturated. This has been grasped and exploited by the pharmaceutical industry who markets such products as '*umuthi wenyoni*' (an antacid, named to make it sound culturally relevant). It has a similar fragrance as that of the traditional '*iyeza lepleyiti*' which is used for cleansing the digestive system of new born babies; it thus sounds and smells like something familiar and cultural. What the commercial world has been quick to accept, has not been as acceptable to the biomedical world.

Indications were that women had no difficulty in relating their experiences of *ukuhanjwa* in themselves and their children, unlike men, who distanced themselves regarding child rearing and the illness. This is likely to be because of the fear of being seen as weak.

It is important also to note that this study fills in the *lacunae* that was apparent to this researcher regarding information in the literature on *ukuhanjwa*. It was this dearth of information which motivated the researcher to explore the illness, so as to contribute to the literature with detailed information. As has always been the case and continues to be the case to this day, traditional people transfer their knowledge from generation to generation orally and have not thought of recording their cultural practices in writing for future generations. They have not thought seriously about the extinction of their cultural practices as a result of acculturation and modernisation as defined by Western countries.

The study has also contributed by providing a conceptual framework for the social construction of *ukuhanjwa* using Malinowski's functionalist approach. The same conceptual framework can also be tested for other *abantu* or cultural illnesses. Another conceptual framework has also been developed regarding the healing pattern followed by the Southern *Nguni* people for *ukuhanjwa* which can also be tested for other illnesses as well.

The study also suggests that interpretations, meanings and language regarding illness experiences can contribute to tensions between the traditional and the biomedical health systems, and can shape the manner in which people respond to illness, health and medicine. Additionally, the study resulted in the establishment of a theory of the 'medical invisibility' of *ukuhanjwa* as conceptualised by the Southern *Nguni* people of ORTDM - a theory which can also be tested for other cultural illnesses. The study has also revealed how the Southern *Nguni* people came to the conclusion that witchcraft is an evidence-based theory, giving them some grounds for refuting the biomedical claim that witchcraft is a theory with no evidence. Lastly, the study also helped in establishing the four sources of healing power in the traditional healing methods for *ukuhanjwa;* the same study can be conducted for other cultural illnesses to check if the same results pertain.

7.3. Implications of the study

The indications are that the Southern *Nguni* people of the ORTDM are deeply committed to their traditional practices regarding *ukuhanjwa,* and are going to continue to consult with their diviners, use their preferred healing methods, and transfer their information on the illness from the present generation to the next.

Southern *Nguni* people have demonstrated great trust in their diviners, who were the first to name and explain this illness. The same symptoms which were identified by diviners generations ago are still used collectively as a means of detecting whether *ukuhanjwa* is present or not. In addition, Southern *Nguni* people have continued with the use of the same traditional healing methods which were prescribed by the ancient diviners for mild and severe *ukuhanjwa* without hesitation. Seemingly, the only function of the present diviners regarding the illness is to detect whether a case presents with severe *ukuhanjwa* or some other illness. With mild *ukuhanjwa*, people have assimilated the cures and generally do not require the diviner. The plants used and ritual space and time in which the healing methods are conducted have not changed.

Interestingly, the trust that people place in diviners is not without individual responsibility. People are aware that there are fakes today posing as diviners. People are generally extremely careful when selecting a diviner, and conduct investigations about the length of time he or she has practised and what his or her success rate is. In this aspect, word of mouth is a great ally.

The strong adherence to traditional healing for *ukuhanjwa* has implications for th*e biomedical world. The study confirms the assertions of some authors that traditionalists use traditional methods as a way of preserving identity and of resisting the pressures brought to bear by a dominant culture. The adherence to traditional healing needs, according to this view, can be viewed as part of a larger struggle to retain an identity that has come under direct and indirect attack since colonial times. It continues now to struggle against the process of globalisation and Westernisation. The Southern *Nguni* as a cultural group are refusing that their culture and

traditional practices be placed in the past as history. Thus the beliefs and practices are not going to fade away; they are consciously held. Unless a person has been removed from the traditional sphere of socialization at an early age in order to erase traditional beliefs and traditional practices, pure transformation of a person from one cultural practice to another without traces of his or her original culture becomes difficult to achieve. What happens with adults when a new culture is introduced is that they may embrace it while adhereing to original beliefs and traditions; the resulting merge of the two belief systems will vary from person to person but will all be evidence of the reality of cultural modernity, and never of 'pure modernity'. For many who become Christians, illness thus becomes a *locus* of spiritual conflict; from the pulpit, they are urged to combat evil spirits with prayer and the guidance of the Holy Spirit, and at the same time to use biomedical healing methods, and not traditional healing methods. For many the struggle to resolve the competing demands of two cultures is extremely difficult. The use of the so-called 'Dutch' medicines or inigenized household products seems to be a way of adhering to traditionalism while avoiding consultations with diviners, which are frowned upon by the church. Indigenized medicine is thus often the preferred route for younger people expressing some affiliation with charismatic churches.

If the biomedical health system has the intention of overpowering the traditional health system, it may need to adapt its strategy. One of the strategies could be that of paying attention to the interpretations traditional people give to their illness experiences. The process of persuasion surely begins with fully understanding the point of view of the other person so that points of commonality and divergence can be identified and assessed.

One of the authors in the literature review has suggested that tests conducted on the efficacy of the biomedical healing method should be done simultaneously with tests on the efficacy of traditional healing methods. Both should be conducted on a variety of patients suffering from the same conditions. This would establish whether claims of each group are true or false. This seems possible in only a small number of cases, as it immediately brings to the fore the different definitions of health and illness. How does one measure the spiritual? Those who subscribe to the biomedical model could still experience difficulty in understanding and interpreting healing from a spiritual point of view, thus requiring the input of a traditionalist who would have to indicate whether spiritual healing has been achieved or not. The two systems probably cannot be compared in a biological way as has been proposed.

The interpretation of *ukuhanjwa* as a spiritual illness has to do with both its symptoms and the absence of pain. According to traditionalists, pain is present in both naturalistic and spiritually caused illnesses, making it difficult at times to discern whether an illness is purely naturalistic or spiritual. In many cases the pluralistic approach is used to address both aspects, and the healing cannot be categorically ascribed to either one of the remedies. But in the case of *ukuhanjwa*, the absence of pain marks it out immediately as a spiritual illness. Thus the pattern of help seeking is clearly defined, and traditional healing methods will be the first preference. This is still a matter of interpretation of illness experience. The fact that there have been different interpretations regarding the illness from the traditional and biomedical perspectives implies that disagreements and misconceptions will continue.

Three approaches are used for illness; the traditional, the biomedical, and the combination of both. This implies that there are three directions which could be taken. The first direction could be that of the biomedical health system being successfully convinced that *abantu* or cultural illnesses do exist and are real – something which might lead to the establishment of an integrated medical system. The second direction could be that of traditionalists being convinced by the biomedical health system that *abantu* or cultural illnesses exist mostly in their imagination and have no basis in reality – a reality which is as Westerners have defined it. This might lead to an exclusively biomedical health system. The third direction could be that of maintaining the status quo of the British medical system – a tolerant, yet condescending medical system, whereby the South African government extends tolerance to the traditional health system while preventing it from operating at the same level as the biomedical health system. It implies that traditional health care will remain in its lower status and the hegemonic tendency of the biomedical health system will continue. Should this be the case, there are nevertheless certain things biomedical practitioners can be made aware of, to inform their interactions with patients and improve their possibilities for successful healing.

Preventive measures for illness are generally held in high esteem and are actively promoted by Western culture. Yet with *ukuhanjwa*, despite its severity and possible fatal consequences, no preventative measures are used, despite their availability. This is because the illness is known to occur infrequently, and people can find little motivation to justify the continued alertness and vigilance that such preventative measures would imply. According to the Southern *Nguni* understanding, once the application of medicines for *ukuhanjwa* is discontinued, the smell is

absent and the person is automatically vulnerable and open to attack. And yet no measures are taken to prevent this.

The lack of a systematic way of preventing the illness has implications for health care in the broader sense. One might assume that as long as Southern *Nguni* people do not notice a threat to their lives, they find little reason to break with habit. For *ukuhanjwa*, sustained action over years would be required to be assured of its prevention, and people are unwilling to take this route. Similarly, they quickly fall away from any long-term practice adopted for prevention. Thus any medical protocol requiring consistency and patience is apt to fail, particularly if it is supposed to be adopted indefinitely with no likelihood of ever stopping. The same way of thinking seems to be evident in the reported resistance to using condoms for the prevention of HIV/AIDS and unwanted pregnancies. Recent reports on TV indicate that instead of increasing, the rate of condom usage in South Africa is dropping, with implications for HIV/AIDS and pregnancy statistics. A lack of consistency also extends to the treatment for HIV/AIDS; getting people to adhere to a long-term treatment regimen is extremely difficult. It has also been observed in the case of tuberculosis (TB), where patients are inconsistent in taking medications, and drop their use as soon as they begin to feel better, despite warnings not to do so.

Thus, Southern *Nguni* people have demonstrated a preference for once-off measures, rather than long-term, consistent measures. Polio, for instance, is dealt with in a more once-off manner, and there would be no requirement for consistency over the long term. Some people even state that there is no preventative measure for *ukuhanjwa*, whereas others confess that there is, it is just that people do not wish to engage with preventative measures. Hence with *ukuhanjwa*, the

practice is to respond swiftly and thoroughly, but only for the short term. People do not underestimate the danger; in their view, they believe they are open to attack at any time; the problem is that people lack the ability to maintain consistency for extended period of time in the field of illness, health and medicine. Knowing these facts might enable biomedical practitioners to fully grasp what they "are up against" – it is not just forgetfulness, but a deep-rooted preference for dramatic, short term measures and a lack of experience with slow, consistent measures for prevention.

Ritual and symbolism play a big part in Southern *Nguni* healing; indeed, an element of ritual is present in biomedical healing, too, and forms a part of all people's experience of healing. For Southern *Nguni*, there is a ritual time and ritual place for healing to take place and the practices for these things are accepted as uniform, with little deviation ever experienced. The usual experience is that rituals in the biomedical world are completely alien to traditional people. For example, naturalistic illnesses are accompanied by pain and spiritual illnesses are often not accompanied by pain; this is a ritualistic understanding which clashes with the biomedical understanding. Once pain is absent, people begin to seek spiritual solutions and this takes them in a different direction to the way of biomedical healing.

Regarding the ritualisation of time and place, and the manner in which medicines should be administered, clashes arise between traditional beliefs and biomedical practices. Traditional healing methods which stipulate time of day for collecting plants, the place for preparing them, dosages and the manner of application would not be approved by the biomedical health sector. The issue of symbolism and ritualisation in the biomedical health system is disguised and

watered down, but it is present. People have come up with different forms of rituals and symbols in relation to illness and health that calm their nerves and help establish a sense of control. An example can be made of people who believe in the power of injections rather than taking pills. Their belief would be that they will be healed more quickly with an injection. To them the needle has symbolic value; they believe it will bring about a speedier recovery than pills, which have to go through the whole process of being digested before they begin to work, and this process is unseen, time consuming and mysterious. We also see an element of ritual when people are instructed to take medication at certain times of the day and in a certain sequence. This ritual means a lot to the doctors, but is not understood by the traditional patients. For example a patient could be told to take a pill three times a day – in the morning, noon and evening. But when a patient realises that she has forgotten the morning pill, she may decide to take two pills at noon to cover for the morning pill she forgot, without questioning the implications of the timing. For as much as there is a ritual time and place in traditional medicine there is also a ritual time and place in biomedical healing for them to work properly, and these ritual performances may clash, leading to a lot of misconceptions.

Ritual actions are apparent too. When a person takes the traditional medicinal plants for *ukuhanjwa*, the face tightens up as a result of the taste, and this is an important factor, indicating that the bodily parts will do the same when the medicine begins to work. The same principle applies to the oozing of the black liquid from the wound of the participant who believed that this oozing symbolised the actual healing, the release of poisons which had been put into her by witches. This interpretation was confirmed as complete healing was effected after a relatively short time. As a result of these experiences with traditional medicines, people could very well

expect similarly dramatic and visible evidence of healing when they visit biomedical health centres. They are accustomed to strong tastes, visible evidence and a degree of discomfort when experiencing healing. Slow, steady and consistent, unseen processes negatively impact on the trust of traditional people on the efficacy of biomedical healing methods. Additionally, traditional people do not attach a high significance to the ritual timing stipulated by biomedical health centres concerning the application of healing methods. This could be because they are too accustomed to their own ritual timing and spaces, to the extent that they may even apply their own traditional procedures when using biomedicine as an expression of cultural modernity (using modern medicines in a traditional manner, rendering them less effective than planned).

This brings the discussion back to the fact that traditional people fare best when medicines are dramatic, once-off and involve dramatic actions or strong tastes. They are not put off by cures which are unpleasant to take. In fact, they prefer this. What does not work is slow, consistent treatments which work in unseen ways.

Southern *Nguni* people link the source of the healing power to the spiritual power of God in the creation of the bitter, sharp taste of the medicinal plants as well as God's creation of the very strong smell of the medicinal plants used for healing *ukuhanjwa*. The taste and smell indicate God's spiritual power in the features of these plants. Most biomedical physicians, though they may have a personal belief in God, do not ascribe the healing power in plants to God's power and, as indicated by Davis-Floyd (1990, p277) their view of the human body is a mechanistic one, viewing "the human body as a machine that could be taken apart and put back together to ensure proper functioning".

Biomedical physicians rarely take the time to explain their reasons for the ritual timing that they stipulate for biomedical healing methods and medicines. This may have much to do with the time pressures and staff shortages that are so much a feature of modern hospitals. Patients do not understand the significance of the ritual timing and its linkage to the efficacy of the biomedical healing method. An understanding of how ritual timing works in traditional Southern *Nguni* culture may help biomedical practitioners to link their requirements of patients to their patients' worldview. It may be easier to explain the importance of timing when you can use examples from the patient's own life experience.

There is also the issue of belief in healing methods. To biomedical physicians, the trust they have is in the chemical composition of the medicine and the concept of the source of that strength has little meaning for them. Spirituality has not been significant within the biomedical health sector unlike in the traditional health sector – hence the clash of cultures when it comes to illness, health and medicine. Biomedical physicians have never taken into serious account the issue of how patients perceive the source of the healing that the biomedical practitioner is able to offer them. If doctors placed more emphasis on gaining the trust of the patient, that trust would become for the patient the source of the healing power. How people speak about the doctor (his or her reputation), and how he or she handles people as well as his or her methods of healing have to do with the spiritual healing of the patient, and this impacts positively or negatively on the physical healing of the patient. They all contribute to the trust the patient places in the physician. Once trust is placed in a physician, much power will be ascribed to his medicines and methods, and his healing methods will be believed to work. Thus relationship is everything; it

establishes a foundation of loyalty and devotion, which will have great implications for how patients adhere to protocols.

These could be some of the knowledge gaps which this dissertation might fill in order for biomedical practitioners to understand their patients, and perhaps adapt their own practices so as to enjoy greater success in bringing about the health and social change they desire.

It is also the intention of this researcher to publish more work based on the findings of this dissertation so as to inform government and health officials, so that they can develop policies and practices that take the people's reality into account. For those governments which subscribe to biomedical healing methods and reject traditional healing methods, as they apply and practise Western modernity, which has always clashed with traditional practices. It could be a matter of finding areas of convergence and divergence between current practice and some of the ideas proposed, so that social change and development maybe brought about in a harmonious way. The dissertation has certainly not addressed all the issues surrounding illness, health and medicine that are relevant to harmonious social development. The focus was delimited to one *abantu* or cultural illness and that has kept the findings and conclusions fairly narrow. A call is extended to other researchers to conduct further research in areas of concern regarding the practice of health, healings and medicine. This would minimise misunderstandings and help establish a common ground for social development which would not leave one culture feeling inferior and another, superior.

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APPENDIX A

These symbols are relevant throughout the report:

 - Male

 - Female

 - Child of

 - Married to

 - All the names marked with an asterisk are not participants' real names.

APPENDIX B

University of KwaZulu-Natal
Faculty of Humanities
School of Social Sciences
Department of Anthropology
Howard College Campus, Durban, KwaZulu-Natal, South Africa
Tel: 047-5342 172; Cell: 083 3606 175
E-mail: 212530435@stu.ukzn.ac.za / kngqila@gmail.com

NAME OF INTERVIEWER: _____
SITE OF INTERVIEW: District Municipality: _____Local Municipality: _____
DATE: _____TIME: _____
PARTICIPANT INFORMATION: AGE: ___GENDER: ___DESIGNATION: _____NAME OF LOCATION: _____

SECTION A. CONCEPTUALISATION OF *UKUHANJWA*

a. Mention the different forms of *ukuhanjwa* you know.

_____
_____
_____

b. Mention the identifying symptoms of the different forms *ukuhanjwa* you know.

_____
_____
_____

c. State causes for each form of *ukuhanjwa* you know.

_____
_____
_____

d. What motivated your conceptualisation of *ukuhanjwa*?

_____
_____
_____

SECTION B. HEALING METHODS OF UKUHANJWA

a. Which methods of healing *ukuhanjwa* do you use? Mention the different forms of healing methods you would use / have used for healing *ukuhanjwa* in your infant.

_____
_____
_____

b. Narrate the history of each form of healing method and how it was discovered.

_____
_____
_____

c. How does each form of healing method work? This should include both medicines and rituals.

_____
_____
_____

d. How do you know that the baby has been healed?

_____
_____
_____

SECTION C: THE SOURCE OF THE HEALING POWER

a. What makes you to conclude that the medicine has worked to heal the baby?

_____
_____
_____

b. What is the source of the healing power of the method used?

_____
_____
_____

c. What is it that indicates the source of the healing power of the method used?

_____
_____
_____
_____

SECTION D: ADDRESSING FEARS FOR THE ILLNESS

a. What is it that is scary about the illness?

_____
_____
_____

b. How do you prevent the baby from being 'attacked' by *ukuhanjwa*?

_____
_____
_____

c. Do those procedures help to prevent the illness from 'attacking' the baby?

_____
_____
_____

SECTION E: MOTIVATION FOR THE CHOICE OF THE HEALING METHODS

a. What motivates you to use particular forms of healing method(s)?

_____
_____
_____

b. Who recommended it / them to you and for which reasons?

_____
_____
_____

c. What made you to even consider the recommendation?

_____
_____
_____

d. Explain if the healing method successfully healed the baby.

_____
_____
_____

SECTION F: PERCEPTIONS ON ALTERNATIVE METHODS OF HEALING *UKUHANJWA* OTHER THAN THE PREFERRED METHODS

a. In case of the failure of the preferred healing method of *ukuhanjwa*, mention the alternative method in healing you opted for.

_____
_____
_____

b. Mention reasons for the option chosen.

_____
_____
_____

c. How successful was the alternative method in healing the *ukuhanjwa* in the infant?

_____
_____
_____

d. Who recommended the alternative method to you?

_____
_____
_____

e. What were the reasons for the recommendation?

_____
_____
_____

f. What was you first thought or reaction on the recommendation?

_____
_____
_____

SECTION G: PERCEPTIONS OF THE SOUTHERN NGUNI ON THE ROLE OF BIOMEDICINE IN RELATION TO UKUHANJWA

a. How do you relate biomedicine to *ukuhanjwa*?

_____
_____
_____

b. To what extent would you recommend the use of traditional healing methods for *ukuhanjwa*?

_____
_____
_____

c. Which recommendation would you give to people in relation to healing methods of *ukuhanjwa*? Would you recommend for the traditional healing method to be used alone without being mixed with any other form / traditional healing methods to be used concurrently with biomedicine as an additional perspective / as an alternative when biomedicine has failed / use biomedicine when traditional healing methods have failed / immediately consult modern medical sector for biomedicine to be used as a healing method for *ukuhanjwa* in infants?

_____
_____
_____

d. What would be reasons for your recommendation?

_____
_____
_____

e. What is your perception on the hegemonic tendencies of biomedical models of health as against traditional medicine and traditional healing methods?

_____
_____
_____

Thank you for participating in the study. For further information, be free to contact the researcher using contacts provided above.

APPENDIX C

O. R. TAMBO DISTRICT MUNICIPALITY

OFFICE ADDRESS:
O.R. Tambo District
Municipality House
Nelson Mandela Drive

POSTAL ADDRESS:

O.R. TAMBO
DISTRICT MUNICIPALITY

TEL: (047) 501 6400
(047) 501 7000

FAX: (047) 532 6518

TO : Ms K.H. Ngqila

FROM : Office of the Municipal Manager - OR Tambo District Municipality

SUBJECT : Granting permission to conduct research

DATE : 19/02/2013

Dear Ms Ngqila

Permission has been granted for you to conduct research in the OR Tambo District Municipality as requested. The office is also hoping to benefit from the outcomes of the research in the attempt to improve health conditions in the OR Tambo District.

The office is always pleased to work with community members.

Regards,

Mr. H.T. Hlazo
Municipal Manager

APPENDIX D

The OR Tambo Regional Office of the Chiefs

Nelson Mandela Drive

Mthatha, Eastern Cape

Tel: _____

Cell: 0767905375

E-mail: _____

Date: 05/12/2012

Dear Ms Ngqila

Permission has been granted for you to conduct research in the OR Tambo District Municipality as requested. The office is also hoping to benefit from the outcomes of the research in the attempt to improve health conditions in the OR Tambo District.

The office is always pleased to work with community members.

Regards,

Nkosi Mtirara Bovulenguie Mthatha

APPENDIX E

Map of South Africa (Source: http://www.google.co.za/search?q=south+african+map... [03/03/2015])

APPENDIX F

Map of Eastern Cape Province, South Africa (Source: http://www.temba.co.za/southafrica/easterncape/ [03/03/2015])

APPENDIX G

Map of OR Tambo District Municipality, Eastern Cape, South Africa (Source: http://www.localgovernment.co.za/district/view/6/or-tambo-district-municipality/ [03/03/2015]).