

Introduction

What Is “Traditional” about Traditional Healers and Medicines?

MR. MAFAVUKE NGCOBO AND THE CASE OF THE NOT-SO-TRADITIONAL HEALER

Mafavuke Ngcobo, a licensed African *inyanga* or “traditional” herbalist (as opposed to diviner or rainmaker) in the province of Natal, South Africa, gained the attention of white chemists and government authorities when he turned his small herbal practice in decidedly “untraditional” directions in the 1930s. In contrast to the colonial stereotype of the “witch doctor” reciting incantations to the dead over a mysterious bubbling brew, Mr. Ngcobo practiced medicine in ways uncomfortably familiar to white urbanites. Not only did Ngcobo use the title “doctor” (until reprimanded by the court), but he advertised himself in pamphlets as a “native medical scientist.” Reverend Qandiyane Cele, who wrote a supporting letter to the Chief Native Commissioner, emphasized Ngcobo’s credibility by pointing out that his “chemist” shops operated along “a European system.”¹ By 1934, Ngcobo owned five *muthi* (African medicine) shops in and around the city of Durban, as well as a lucrative mail-order business that sold bottled medicinal remedies labeled in both Zulu and English. His remedies contained local herbs, some Indian remedies, and, more controversially, chemist drugs and patent medicines. In addition, in 1928 Ngcobo helped establish the Natal Native Medical Association, a professional organization of African herbalists that tested dues-paying members on their knowledge of “native curatives.” This organization (albeit a small one) lobbied the government for “native medical rights,” hired lawyers to defend its members in court, and became quite adept at capturing media attention. Such

seemingly “untraditional” behavior troubled the local white medical establishment, and in 1940 Ngcobo went on trial for “carrying on the business of a chemist or druggist.”²

“Traditional” healers, of which there were many types, specialized according to their talents and calling. Historically they performed a variety of functions for African communities; these included bringing rain, detecting witches and criminals, “doctoring” armies, negotiating with ancestors, and using herbs and surgical procedures to cure and mend the body. Ngcobo’s very success as a “not-so-traditional” healer, however, represented larger transformations in African healing practices that occurred between the 1820s and 1940s, particularly in the areas of Natal and Zululand (the former Zulu kingdom). This period saw healers transform themselves from politically powerful men and women who threatened to undermine colonial rule and law in nineteenth-century Natal into successful venture capitalists who competed for turf and patients with white biomedical (Western and allopathic) doctors and pharmacists in the early twentieth century.³ Healers not only adjusted to the political, social, and economic factors that accompanied British colonial rule, but found their status dramatically affected by provincial legislation. Beginning in the 1860s, white legislators criminalized all types of healers, but in 1891 made the unique decision to license African midwives and inyangas. Not all traditional healers adopted Ngcobo’s practices or competed with whites in the same manner, yet in a budding multitherapeutic society many rural and urban healers had begun to incorporate and experiment with medical and non-medical substances associated with South Africa’s other population groups. This blurring of medical as well as cultural boundaries made white medical practitioners and government authorities quite uncomfortable and raised important questions regarding the very nature of so-called traditional medicine and the role of licensed inyangas.

Ngcobo’s trial not only brought many of these particular issues to light but also demonstrated the difficulty in trying to characterize exactly what was “traditional” about “traditional medicine.” On one side, white administrators, doctors, and chemists argued that “native medicines” were static and unchanging and should be defined largely as the absence of what was considered “white,” that is, exclusive rights to biomedical ingredients, titles, tools, practices, scientific methods, and white patients. Conversely, the Natal Native Medical Association, Ngcobo, and his lawyer argued that African therapeutics were dynamic and experimental and changed with the times. Problems encountered in legally codifying this medical tradition, however, resulted largely from the ambiguity of past legislation, particularly the 1891 Natal Native Code, which had originally legalized and licensed the practices of African midwives and

inyangas. The code's writers presumed the concepts of native and European medicines as self-evident and obviously and inherently different. The only legal restriction placed on licensed inyangas was a caveat specifically banning the sale of "love philtres or charms." In 1932, administrators sought to more clearly distinguish these two medical cultures by amending the code to explicitly state that inyangas "may prescribe, deal in and sell *native medicines only*."⁴ The Ngcobo trial was yet another attempt to disrupt the "development of a new *hybrid* system" that had clearly begun at a much earlier date.⁵

In determining what constituted "native medicines" or "traditional methods" of healing, the prosecution, like the white administrators before them, sought to establish the "authenticity" of so-called native customary law by turning to the requisite African "experts" or old African men. At the 1940 trial, the testimony of Ngcobo's own employees, and an elderly licensed inyanga from Port Shepstone who bore no relationship to Ngcobo or his business, provided the bulk of the prosecution's evidence. Their testimony showed that although Ngcobo's own workers characterized some medicines as "European" and others as "African," they disagreed on the origins and use of others. Ngcobo's employee of twelve years, George Mvuyane, told the court: "Everything you buy from a chemist shop is a European medicine and everything you go and dig for is a native medicine."⁶ Gonzaga Qhobosheane, another worker of Ngcobo's, and Ndabakohliwe Kuzwayo, the seventy-year-old exemplary inyanga, argued that native medicines also included animal fats, skins and bones, and minerals. With regards to medicinal plants, these African witnesses distinguished "native medicines" by whether they grew wild in Natal and Zululand. By the 1940s this involved a number of exotic species to include ones prepared by local chemists such as jalap (Zulu: *jalambu*) from South America and male fern (Zulu: *nkomankoma*) from Europe and North America. While Africans designated wild exotic plants as "native," some native plants, such as croton seeds, referred to by Mvuyane as *nhla kwa zaseIndia*, which indicated an Indian influence, assumed exotic connections. The origins of other substances such as mercury (Zulu: *sigiti*) seemed to defy classification, perhaps because both Ayurvedic (Indian) and biomedical practitioners used it. Kuzwayo said he knew no "medicine men" in Port Shepstone who used it, while Qhobosheane claimed it was quite common all over the country.⁷ Despite the evidence of African healers and the fact that wild exotic plants introduced by early white traders and settlers had been growing in the area for more than a hundred years, the prosecution argued that "indigenous" medicine should include only *indigenous* plants of South Africa. The defense argued against a double standard that enabled the British pharmacopoeia to include many foreign herbs and materials but limited "native medicines" to indigenous South

African substances.⁸ Instead the defense suggested a definition that included all herbs grown in South Africa and medicines regularly and long used by “native medicine men,” such as jalap, male fern, and mercury.

The importance for the prosecution to clarify this first issue becomes evident when considering the next: how should licensed African practitioners secure and prepare their remedies? Again Kuzwayo, serving as the primary witness, testified that he dug up many of his own herbs and roots and killed snakes and iguanas, but bought fish bones from Indians and some “native medicines” in Durban (most likely from the native markets along Victoria Street). He did not purchase medicines from white chemists. While he agreed that inyangas typically used bottles for prepared medicines, he claimed that Ngcobo’s shops had a greater number of bottles containing a larger variety of substances than he had ever seen in an inyanga’s practice.⁹ Native medicines, he testified, could be prepared by chopping, cutting, burning substances to ash, by cooking and by adding medicinal material to water.¹⁰ Ngcobo’s defense did not challenge these contentions, but again highlighted the duplicity of the law that enabled innovation among white medical practitioners while denying it to Africans. For instance, he pointed out that chemists had historically compounded their own medicine, yet the rise of wholesalers had made this practice less necessary. Certain herbal remedies regularly used by African herbalists, like male fern, were now available in tincture form (at many chemist shops). Why, the defense asked, could the African practitioner not also save time and energy through their purchase?¹¹ Given that Mr. Ngcobo was found to possess his own supply of various preservatives and patented medicines, these particular arguments—while raising important questions—came across as somewhat disingenuous.

In the end Ngcobo was fined £25 and charged with “not acting within the rights conferred upon him by his license as a native medicine man and herbalist.”¹² The presiding judge rejected the defense’s argument regarding healers’ uses of nonindigenous substances. Instead he ruled that “native medicines” are “characteristically *native both in origin and composition*, that is medicines compounded and prepared from roots, bark, herbs, leaves, fats, skins and bones and other *indigenous* substances.”¹³ On appeal, Judge Feetham argued that this category should include “medicines such as natives can make for themselves by comparatively simple processes, not requiring a high degree of scientific skill, *out of the natural substances of the country which are available to them.*”¹⁴ While it is not entirely clear from this latter characterization whether exotic jalap could be used by inyangas, the distinguishing feature for Feetham was the degree of sophistication with which these different medical practitioners mixed or compounded medicines. Like other imperial thinkers

of the time, Feetham's emphasis reflected an imagined binary between European and African societies, the assumption of European rationality and science as contrasted to African irrationality and simplicity. Likewise, European society was deemed modern and innovative while African customs or traditions signified the past. African "traditions" were not meant to be adaptable or improved on but a temporary juncture that according to the judge would eventually give way "by degrees, as education and civilization extended."¹⁵

This court case is particularly interesting because it not only shows the difficulty in determining what is "traditional" about "traditional" medicine and healers in the 1940s, but also exposes some of the politics behind the courts' desire to codify African medicine. While Ngcobo's case provides evidence of medical cultural exchange, it also demonstrates the establishment's decided lack of interest in certain group interactions—such as those of Africans and Indians—which are evident but unremarkable to the court.¹⁶ Instead legal arguments were cloaked under the veil of maintaining African "authenticity," while the real contention remained one over economic and ideological competition between African and white medical practitioners. This competition, rarely acknowledged, stretched far back into the nineteenth century and involved a variety of actors. Such rivalry is essential to note, as it not only upsets conventional notions of traditional African and biomedical medicine but demonstrates that medicine was yet another arena for larger colonial contests over political and cultural hegemony. The results of this competition influenced the ways in which biomedical and African healers came to conceive of themselves and largely limited healers' legal status under white rule.

Some sixty years later, in August 2004, a multiracial and democratically elected South African parliament officially recognized traditional healers and set in motion a legal framework to license them throughout the country. An Interim Traditional Health Practitioners Council was charged to "provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training, and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith." Consequently, more than 350,000 traditional healers, who attend the majority of the South African population, will gain access to the benefits and burdens of medical regulation. While the recently adopted Traditional Health Practitioners Bill is generally more descriptive than past legislation, the legal definitions used to characterize traditional medicines and health practitioners are still somewhat ambiguous. Ironically, like earlier medical legislation under white rule, the 2004 bill defines traditional medicines and practitioners by the absence of biomedical substances

and practices and assumes them to be self-evident. For instance, the law stipulates that “traditional health practices” are based on “traditional philosophy,” which is then defined as “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines . . . which are generally used in traditional health practice.”¹⁷ Again, while such a definition might seem straightforward and obvious to most, the terms “traditional” and “indigenous” mask a complicated history and more problematically pose the assumption of “indigenous” traditional medicines.

In this book I explore the history of what is today deemed “traditional” African medicine. In particular, I examine how the practice of African therapeutics and whites’ perceptions of African healers changed, both during the precolonial period and as traditional healers faced the challenges that came with white rule. In doing so, I analyze two related phenomena: how knowledge and culture are used to assert, challenge, or elide hegemonic forces and how such notions are adapted, produced, and negotiated between population groups with different interests, cultural beliefs, and access to power. My objectives are twofold: (1) to show that while African or local medicine has maintained certain core beliefs over time, it also has been dynamic and sometimes open to non-African beliefs, practices, practitioners, and substances; and (2) to demonstrate that within African history, medicine was an important site of power, contestation, and cultural exchange that not only reflected but also affected intergroup relations. By indicating the fluidity of African therapeutics and the dynamics of group encounters regarding health and well-being, I seek to challenge conventional understandings of cultural and medical boundaries. This study is grounded in the specific historical circumstances of South Africa, predominantly within the culturally plural province now known as KwaZulu-Natal. By beginning with the founding of the Zulu Kingdom in the 1820s and ending in 1948 with the election of the Nationalist Party, I examine the role and history of African medicine and healers in an independent African nation, during the period of colonial encroachment and white rule, and before the onset of apartheid rule. Though some of the phenomena discussed in this study are unique to the province of Natal and Zululand, like the licensing of healers and its large Indian population, the province’s history helps to shed light on the transformations and dynamics of local therapeutics and intergroup encounters found in many colonized states.

Of necessity, this study moves away from more conventional medical histories and notions of medicine, particularly in its consideration of medicine’s power to affect social and political change. Beginning with the emergence of the Zulu kingdom (1820–79), it is clear that African healers played an important role in upholding the authority and national identity of a new Zulu nation.

African healers and therapeutics healed not only the physical and social body, but the body politic. As the Zulu kingdom emerged and consolidated its power, medicine helped defeat Zulu enemies, strengthen the king, and create a new sense of national pride and obligation (see chapter 2). Even after the defeat of the Zulu nation by the British in 1879, healers continued to play an important role in maintaining local beliefs and power structures that challenged British rule. Some of the most contested moments of the colonial encounter occurred when African communities suspected witchcraft as the cause of death or illness and defied British law by seeking out local healers to confirm their suspicions. By expanding this study to include wider and local notions of medicine, we see how African therapeutics were used as a form of social control and a tool of the Zulu empire, but also why white native administrators and legislators in neighboring Natal (1830–91) reacted as they did to a certain subset of African healers within their own territories (see chapter 3).

To understand how people conceive what is “traditional” about traditional medicine, we must consider cultural actors and processes not commonly associated with African therapeutics—that is, white biomedical practitioners, Indian healers, and the implementing of white rule. As the Ngcobo case demonstrates, within KwaZulu-Natal, important players included African healers and their patients, indentured and ex-indentured Indians, white biomedical practitioners, and government administrators. White rule contributed both deliberately and accidentally to the rise of a multitherapeutic society as well as to the interaction of these various parties. While the region’s medical “traditions” and cultures—African, Indian, and European—often have been treated as their own “systems,” bounded and separate from each other, this book argues that this was not the case.¹⁸ Not only did each community exhibit its own medical plurality, but the historic interactions of these various cultural entities affected the practice of the others to varying degrees. Understanding the history of medicine in South Africa thus requires an examination of how these groups interacted and the sites, actors, and circumstances that constructed these medical cultures.

Medical competition between the region’s various therapeutic groups played an important role in this interaction, in turn influencing how South Africa’s different medical practitioners came to envision themselves and their own medical authority. Again, as the Ngcobo case illustrates, biomedicine sought to establish its authority by invoking notions of science and racial superiority while legally restricting “African” medicine and its practitioners from using “white medicine” (see chapter 4). African and Indian practitioners, on the other hand, sought to modernize and professionalize their occupations by winning the confidence of a new multiracial urban clientele while

Who gets to represent traditional healers? Traditional healers posing in the 1880s and in 2002.



Henry Kisch, *Photographs of Natal and Zululand Album* (1882). Killie Campbell Africana Library, C8105.



Indian *inyangas* in an Indian *muthi* shop in Ladysmith, KwaZulu-Natal. Photo by author, 2002.

also seeking to circumvent the legal restrictions imposed upon them. An examination of the political, social, and economic encounters of such practitioners and their patients demonstrates the multicultural origins of so-called indigenous medicine and the ways in which African medicine negotiated and sometimes resisted its encounters with South Africa's other medical communities. By delineating the plural cultural heritage of African medicine, I seek to raise important questions regarding traditional medicine's "indigenous" nature, demonstrating that groups such as Indian inyangas not only used so-called indigenous medical knowledge, but shaped and contributed to it as well (see chapter 5). Consequently, my work challenges academic and popular notions of cultural exchange in South Africa and contributes to a growing body of scholarship focused on the construction of cultural identity.

EXAMINING NOTIONS OF TRADITION

Tradition has been a central concern to scholars of Africa since the early twentieth century, though understandings of this somewhat nebulous concept have changed radically since then. Initially the domain of anthropologists and colonial administrators, studies of African tradition helped colonists to draw up customary law and better implement colonial rule. Such scholars were often motivated by the belief that tradition needed to be documented and preserved against the rising and destructive surge of modernization, colonialism, and urbanization. Consequently such studies often ignored the rapid transformation that accompanied white rule, seeking instead to describe African cultures as free from European influence and as largely static and unchanged. E. E. Evans-Pritchard's seminal work on witchcraft and the Azande, for instance, unrealistically insisted that despite the Azande peoples' having been displaced and forced into government settlements set up to control sleeping sickness, such events had "not produced any great change in the life of the Azande."¹⁹ The search for African "authenticity" and tradition was largely replaced in the 1940s by studies that examined the very transformations and structural changes engendered by white rule while still treating what preceded it as static.

By the 1980s, there seemed to be a major rethinking of tradition, in terms of both what it was and how it was used. Jan Vansina wrote influentially about the meanings and history behind African oral traditions—the stories passed down through generations that usually told of past rulers and the establishment of a people or a nation. Some traditions, such as that of "Sundiata," which told of the establishment of the Mali kingdom, went as far back as the thirteenth century. Vansina argued such traditions reflected the present as much as they offered a window into the past. He demonstrated how performers

appealed to the needs, questions, and desires of a contemporary audience.²⁰ While Vansina believed that it was possible to access evidence of the past through such traditions, particularly through examining metaphor and comparing regional oral traditions, it was also clear that new historical circumstances meant such traditions had often been changed by various narrators over the years. Such adaptability, Vansina argued, enabled the very durability and relevance of traditions. As he wrote later, traditions “must change to remain alive.”²¹ Yet he also warned that traditions could perish altogether when the basic principles underlying a culture or society were forgotten or discarded in favor of another incongruent tradition.²²

Adopting this idea of a changing and adaptable tradition, other scholars sought to examine the ways in which tradition had been constructed. Following the influence of Terence Ranger and Eric Hobsbawm’s *Invention of Tradition* (1983), African historians began to question the very nature of what had been construed as African “tradition.” Clearly European discourse on African “tradition” had been self-serving, leading white rulers such as the judge presiding over Ngcobo’s court case to create a false binary that painted African “tradition” as the antithesis to European “modernity.” Yet what impact did such a discourse, and, as V. Y. Mudimbe argues, an academic scholarship on Africa replete with non-African categories and epistemologies, have on African practices?²³ Scholars turned to examining the ways in which colonialism and customary law helped to construct rather than reflect so-called traditional African identities, customs, ethnicity, religion, and gender relations. Authors argued that colonial officials with limited knowledge of African realities had codified, classified, and changed African cultures. In doing so they had helped to shape and influence that seeming reality. Ten years after publishing his and Hobsbawm’s seminal book, Ranger reexamined how his initial thesis had been expanded and challenged by more recent work on tradition and Africa. He concluded that it was necessary to revisit some of his original assumptions about the power of the colonial state to shape tradition. Likewise, scholars began to ask how successful colonists had been in reifying these so-called traditions. While the colonial state seemingly changed and shaped tradition in the public arena, research showed that it had less of an impact in the private sphere. Ultimately colonists could not control the ways in which practices and ideas were interpreted or imagined by the colonized.²⁴ While earlier scholars had posited a break between precolonial and colonial traditions, later historians challenged this.²⁵ Steven Feierman, for instance, agreed that colonialism had been interventionist but pointed to African agency in the shaping of new traditions. In particular he examined the role of “peasant intellectuals” who used both the past and an enlarged “tradition” to meet contemporary needs.²⁶

More recently, scholars have expanded their examinations to the *process* by which tradition was/is constructed. This includes studying the role of African mediators, often male, literate, politically invested, and with access to white administrators. Such actors served as cultural brokers or translators who not only helped to make colonial ideas and practices more palatable to Africans but also had an influence on the way colonial administrators understood and reacted to the African community.²⁷ In essence, tradition, like many other concepts, is not only mutable but can be employed strategically for specific ends by both the colonized and the colonizer.

Scholarship on African therapeutics has in many ways mirrored the historiography of tradition, primarily because African therapeutics itself has been identified as an important component of African tradition. Yet attention to its historical construction and the importance of its contributing actors and sites has been largely absent. By examining African therapeutics historically, I show that traditions are fluid, contested, open to cultural exchange, and a means of asserting power. Furthermore its construction involves both colonial meddling and the work of cultural brokers and also reflects the will and concerns of the general public.

The question of tradition and therapeutics became remarkably important in the years just prior to South Africa's first democratic elections. A rash of human muthi murders and mutilations as well as brutal killings of alleged witches gained the attention of the national press. Healers who were by association implicated in such practices used notions of tradition to counter the negative publicity. Obtaining human muthi, which usually involved the removal of certain body parts from a live person, was not executed by a healer but carried out at his or her instruction.²⁸ From these body parts healers concocted powerful medicines alleged to enhance the wealth and power of the recipient. Likewise the killing of alleged witches, whose prevalence in the northern provinces led to the establishment of two government commissions (1995, 1998), often depended on traditional healers to "smell-out" or identify so-called witches, who were then targeted by vigilante youths.²⁹ Although such incidents have a historical precedent in places such as the Zulu kingdom, where African healers did advocate the use of human muthi and named witches, in the past these practices had taken place under radically different circumstances and, at least theoretically, had not been used for personal gain. The publicity surrounding the violent incidents in the 1990s not only implicated traditional healers both directly and indirectly but tarnished the very image that certain healers had been working so hard to promote. From the 1980s on, healers seeking national recognition for their occupation attempted to reassure national legislators and the public of their honorability. In the early 1990s, traditional healers

launched a public relations campaign that actively condemned muthi murders and the killing of alleged witches as “untraditional” and the work of charlatans rather than genuine healers.³⁰ Politically savvy traditional healers thus employed notions of tradition to distance themselves from and restrict what they considered antisocial behavior while legitimating their own practices.

Today South African healers use ideas of tradition to emphasize their authenticity and legitimacy in a multicultural environment where patients may choose from a variety of different practitioners and therapeutics. Healers thus refer to themselves in English as “traditional healers” and argue that their practices have not changed over time but reflect the practices of their forebears. This reference to ancestors alludes not only to the knowledge passed down through the generations but to the active role that ancestors play in the therapeutic process and passage of knowledge through dreams, trances, and visions. The term “traditional healer” also avoids the negative connotations and inaccuracy of “witch doctor” and is less exclusive than the colonial-derived terms “medicine men and herbalists.” Instead, the designation encompasses both women, who make up a large percentage of healers, and other types of healers besides herbalists.³¹ This term is used interchangeably but consciously throughout this book with the term “healer” or “medical practitioner.”

The utility of tradition thus emerges from its flexibility, the way in which it can be called on to support or condemn various actions, practices, and/or beliefs. It is a catch-all concept that connotes the passage of items, images, symbols, events, beliefs, behaviors, customs, or practices from one group or generation to another over the years. When people accept and acknowledge tradition, it is usually because they see its worth and value its continuity. On the other hand, those who find a tradition disagreeable may cast aspersions, claiming tradition to be outdated, nonsense, or superstition. Either way, traditions have tremendous power in their ability to bind people together or to cause generational, family, or community strife and strain. In a postapartheid South Africa, many are reasserting the relevance of “African tradition” and rediscovering “traditions” long disparaged by the previous colonial and apartheid governments. Others, however, are challenging “traditions” such as public virginity testing that have been deemed harmful and discriminatory to girls.³²

Sociologists have determined that the concept of tradition often gains importance during periods of rapid social, economic, and political change; it becomes a means by which to assert a feeling of power over events that maybe outside of one’s immediate control.³³ This seemed to be the case when I began this project in South Africa in 1998. As a historian, I was particularly interested to understand how practices, beliefs, and values of healers had changed over time and space. Yet when I conducted interviews with healers

in KwaZulu-Natal, I discovered that they often did not share this concern, and some vehemently rejected this. Instead traditional healers expressed an interest in talking about what practices and forms of knowledge had remained the same; they sought to write down “the tradition” before it was forgotten. They feared that African youth, in the face of larger social and economic changes, did not value or understand their own history and traditions and would soon lose them altogether. In the face of increased urbanization and globalization and a disappearing local flora and fauna, healers were/are not alone in this fear. During the past ten years, a number of government and university research projects have sought to record the botanical knowledge of South African healers and create a comprehensive database of South African plants for these very same reasons.³⁴ When asked why he worked and shared plant remedies with the pharmacology department at the University of Cape Town, healer Phillip Kubekeli replied, “There must be something written for our future generations, if there is nothing written all our knowledge will just collapse. Truly, look at our children . . . our children don’t even know the first principle of our primary healthcare.”³⁵

Tradition, however, is also often contested as people inevitably have conflicting views over its meaning, practice, or use. As in the Ncgobo trial, Zulu-speaking healers with whom I spoke in the late 1990s often had competing notions of what constituted “traditional” medical practices—be it the appropriate gender of practitioners, how to collect and mix medicines, or the means of acquiring patients. Recently, healers in KwaZulu-Natal were debating the legitimacy of processed herbs and whether this practice falls within the canon of “tradition.”³⁶ The processing of herbs has been practiced for the past century and is largely but not entirely an urban phenomenon which continues to be practiced by a number of KwaZulu-Natal healers and muthi sellers. Yet who should decide whether this practice falls under the realm of “tradition”? What is the process of negotiating such determinations? And how far back does one need to go in history to define “authenticity”? Answering these questions, let alone making them a part of public policy, enforceable by law, is where “tradition” becomes a thorny and controversial issue.

Another important question to ask is, if traditions are so highly valued because of the strong emotive link they provide to the past, can traditions also change and modernize? With regard to the debate over processed herbs, some healers as well as botanists argue that the processing of herbs combined with sustainable harvesting can better preserve a rapidly depleting local flora and consequently the practice of traditional medicine.³⁷ Others point to the need for new forms of preparing herbs to meet the coming regulation and systematizing of traditional medicine planned by the South African government’s

Medicines Control Council.³⁸ While it is unclear what African healers will decide on this particular issue of tradition, the question is clearly prompted by changes within African therapeutics in the past and present. In many ways, traditions are like family recipes; they are not static but subject to change over time. Each generation may improvise to accommodate the availability of ingredients or transformations in technology or to better suit their own tastes, all while attempting to honor the basic recipe. In essence, tradition is like an elastic fabric that is often stretched to meet specific needs. In this way we can see tradition as a cultural construct, subject to change from within and without. While there may be certain values, practices, and symbols that persist over time, there is nothing authentic or essential about them as their importance or meanings shift to reflect society's norms and values. This is not to say that they are meaningless. On the contrary, they have great importance to those who abide by them and possible repercussions for those who do not or for those who are intentionally excluded.

In order to understand what is “traditional” about “traditional” medicine and healers and what has been constructed as “traditional,” I seek to answer some contemporary questions: Why, if certain local herbs are available in pill form, do patients and clients insist on more traditional preparations of these herbs? Do patients see this as primarily an issue of functionality, or does the ritual of preparation serve a deeper social and cultural purpose? Why are pills and many European substances rejected while Indian herbs are embraced by patients and their healers as “African” or “traditional” medicine? Why did the use of precollected herbs and already prepared herbal mixes become largely acceptable, while early to mid-nineteenth-century methods indicate that muthi should be collected and prepared only when a person is ill? Why do many South Africans continue to seek the support of traditional healers despite the fact that, until recently, they have not been covered by medical insurance and their services are often much more expensive than those of biomedical practitioners? Finally, are the current practices of traditional healers the result of historical interactions or merely a reflection of today's multitherapeutic market? By engaging these questions in a historical manner I hope to better ascertain how it is that “tradition” was and continues to be created or imagined and to understand how and why certain aspects of culture have been jettisoned, others maintained, and others—completely new—incorporated over time.

CULTURAL BOUNDARIES AND BROKERS

As a social-cultural historian I am interested to see how culture—in this case an African medical “tradition”—is constructed and reconstructed in the past;

where and how cultural boundaries are drawn; the circumstances that prompt remapping; the role of cultural brokers who assert or assign these boundaries;³⁹ and the sites where boundaries are produced and reproduced.⁴⁰ This book looks particularly at the role that cultural brokers—African, white, and Indian—as well as patients played in shaping the boundaries of “African” therapeutics. Cultural boundaries are important as they determine cultural identity; who is included or excluded—who is Zulu or not Zulu, Indian or not Indian. And in the case of healing, they determine the type of healing—whether practices are identified as African, Indian, or European. Despite the labels applied by white administrators and the general public, these categories are seldom so discrete in reality. Yet notions of such differentiations between cultural groups gain importance when people perceive tangible social, economic, and or political privileges or disadvantages in belonging to one group versus another. This has been true in the case of healing as well.

Cultural boundaries, like tradition, shift to meet changing circumstances. This was particularly true in the rapidly changing and multicultural community of what is now KwaZulu-Natal. While many Zulu-speakers emphasized clan identity in the nineteenth century, a more widespread Zulu identity emerged in the twentieth century as a result of white imperialism and growing Zulu cultural nationalism.⁴¹ Likewise, the South African Indian identity today encompasses a heterogeneous mix of people claiming South Asian, Middle Eastern, Zanzibari and/or Islamic heritage.⁴² This overarching Indian identity emerged between the late nineteenth and mid-twentieth centuries due in part to its imposition by a white-dominated government, but also as communities asserted it to organize and defend themselves politically. Similarly, white South Africans—a number of whom have a mixed genealogy and heritage—may remember genealogical lines from various parts of Europe while forgetting the contributions of Khoisan and enslaved communities of the Cape. Despite the assertion or assignment of boundaries, however, groups are not homogenous, and individuals have multiple identities. As anywhere in the world, South African communities often vary in terms of religion, language, and regional origin and are further split by class, gender, generational, and urban/rural divides. What it means to be “Zulu,” “white,” “Indian,” or, more recently, “African” in South Africa is imagined in many different ways over time and space.

Cultural boundaries are not only prone to shift over time but are porous by nature, particularly where and when cultural groups encounter each other with frequency. What passes as African, Indian, or European medicine has also changed over time. In other words, there is potential for leakage—the diffusion, adoption, and appropriation of other cultural ideas, practices, and

artifacts. The result is a polycultural amalgam that blends together various strands of influence, creating new and sometimes unexpected patterns in the cultural fabric.⁴³ Historians Robin Kelly and Vijay Prashad argue that all cultures are essentially polycultural with a variety of entrance points.⁴⁴ Unfortunately, present-day antagonisms between various groups are seen by many in the general public as natural, the result of culturally distinct groups, rather than as cultural productions that arise from specific historical circumstances.

Within South Africa, white legislators worked hard to reinforce these notions of cultural and racial difference. British segregationists and apartheid legislators sought to hinder the shifting and porous nature of cultural boundaries through bureaucratization and segregation. Yet even under apartheid's Population Registration Act (1950), individuals could be racially and culturally reclassified.⁴⁵ This was sometimes done at the insistence of the state; at other times individuals asserted new identities for practical purposes. Muslim Indian businessmen in the Cape, for instance, sometimes sought reclassification as Malay (a cultural subset of the Coloured population) to maintain property and businesses in "Coloured areas" designated by the Group Areas Act (1950).⁴⁶ White South African legislators, however, focused primarily on preventing cultural exchange between "white" and "non-white" groups, even to the extent that apartheid segregated hospitals, and ambulances were forbidden to pick up patients of the "wrong" race.⁴⁷ Less vigilance was paid to the interactions among "non-white" groups, though legislators also sought to disrupt the permeable boundaries between these groups as well. Divide-and-rule tactics and ideologies of difference were reinforced in race-based apartheid-era schools, through the Group Areas Act, in the public media, and, not surprisingly, these ideas of difference continue to linger in today's public imagination.

In a postapartheid era it is again necessary to revisit these assumptions about cultural difference and to challenge popular notions of group relations. Viewing all cultures within South Africa as polycultural fusions of African, European, and Indian Ocean influences and appropriations allows one to complexify notions of culture and cultural exchange and demonstrate the historic interconnectivity of present-day cultures. But more importantly a history of long-forgotten encounters may disrupt normative ideas of the "cultural divide" that separates communities today. Delineating cultural threads within those exchanges, however, is not always an easy task, particularly as many ideas, practices, and artifacts have been incorporated to such an extent as to be seen as natural or "indigenous" to a particular group. This book attempts to delineate some of these threads with regard to the history of health and healing. In this way, this book serves as an empirical intervention to highlight these connections.

As a writer and historian it is sometimes difficult to avoid perpetuating conventional notions of tradition, culture, and race. The very appellations “European,” “white,” “Asian,” “Indian,” “African,” and “Zulu” connote borders or flatten and homogenize what are otherwise quite diverse groups with different interests, histories, and changing identities. Qualifying a person as “Zulu,” for instance, can inadvertently suggest a Zulu identity or support for the Zulu king, which was or is not always the case. This issue can be circumvented to a certain extent by utilizing the term “Zulu-speaker” or by referring to practices of the precolonial period as “within the Zulu kingdom.” The kingdom’s boundaries (though shifting over time) can be outlined either physically or by association. Within this text I often use the more general term “African” to refer to peoples indigenous to southern Africa; this is not to insinuate that the practices of “Africans” described herein can be attributed to all groups within Africa. Rather this is a way of acknowledging a more heterogeneous group of Africans. Natal became home not only to Africans who purposely escaped the Zulu kingdom, but to other non-Zulu-speaking Africans who sought work or better opportunities in Natal. Likewise the government made distinctions for licensing based on ideas of race—whether or not one was a “native”—rather than Zulu versus Sotho. While most African healers discussed in this book were Zulu-speakers, there were others, such as the wealthy and rather high profile Sotho healer Israel Alexander, who played a prominent role in the Natal Native Medical Association.

As researchers we are somewhat handicapped by the ways that previous writers have recorded history. Archival records, for instance, often refer to persons simply as “Indian” (sometimes “Arab” during the earlier period) and “native”; they do not always make subtler distinctions. Where possible I have noted individuals’ and groups’ class, religion, gender, generation, and level of education (to name but a few variables). Unfortunately both the history of South Africa and its sources lead me to use terms that I am simultaneously seeking to undermine and complicate. I hope by showing how “traditional” medicine in the Zulu kingdom and Natal is dynamic, adaptable, and poly-cultural, I can contribute to larger discussions about the ways in which a Zulu cultural identity has been constructed in the past as it is in the present.

CULTURE-BOUND ILLNESS AND MEDICAL PLURALISM

What makes South Africa particularly interesting for studying notions of tradition and health and healing is its multiculturalism. In the 1930s and ’40s the motto of the South African Union Health department warned: “Disease Knows No Colour Bar.”⁴⁸ Yet the interpretation, meaning, experience, and

treatment of disease often varied greatly among South Africa's different ethnic and racial communities. This is because concepts of health, wellness, and the body, like tradition, are informed by our own experiences and the culture and era in which we live. Different communities often have various ways of understanding the body and illness and consequently diverse approaches to health and healing. For instance, biomedical conceptions of the body privilege a fairly mechanistic understanding of our selves, whereas Ayurveda (what is construed as "traditional" Indian medicine) views the body as consisting of five elements whose make-up determines one of three major body types. In southern Africa, a number of cultural-linguistic groups share the notion of an *inyoka* (an invisible internal snake) or force that resides largely but not only within the torso.⁴⁹ In addition to bodily understandings, many medical cultures consider the environment—physical, emotional, and spiritual—a potent force on well-being and thus a necessary component for determining the root of illness. Within Durban's heterogeneous Indian communities in the 1950s, for instance, illness could be attributed to retribution for sins in a former life, a visitation from a deity, losing faith in a Christian god, neglecting a Hindu house spirit, or witchcraft sent by either Indians or Africans. Determining the diagnosis enabled the patient to seek the proper practitioner and therapy, while an ambiguous diagnosis may have led to a more cautious approach in which several therapies were simultaneously pursued.⁵⁰

Interpretations of wellness thus reflect society's larger cosmological ideas of how the world works and what is healthy and normal. For instance, male-pattern baldness and menopause, sometimes treated as "pathologies" within certain cultures, are readily accepted as natural parts of life in others that do not require medical attention. But culture can also cause individuals to experience very specific bodily symptoms and ailments that may be unique to that particular culture. This could be *umhayiso* or hysteria caused by the administering of love charms to Zulu-speaking women,⁵¹ a trance entered by Hindu devotees during a Kavady festival, or illnesses such as anorexia and bulimia found in communities that promote thinness as an ideal. Anthropologists often refer to these experiences as culture-bound syndromes, as they are not generally shared by other cultural groups.⁵² We may ask: To what extent do cultural practices, ideals, and interpretations influence our sense of well-being? Take for example the rise of reported persons suffering from attention deficit disorder in the United States during the 1990s. Did this reflect American society's decreasing tolerance for distracted or active children and adults? Was the disorder an outcome of the high demands and stress in a postindustrial capitalist society? Or was the record increase in biomedical doctors' diagnoses due to public demand after a new direct-to-public advertising campaign

that popularized the symptoms and promoted a means of treatment?⁵³ Most likely, it was a combination of societal expectation, cultural demands, and patient awareness.

Within multicultural societies where multiple medical cultures survive side by side, people often search out practitioners who share their own medical ideas of the body and their etiology of illness. But many patients also utilize other practitioners and therapies in a plural medical culture. This may be because their own medical remedies failed or became unavailable or expensive, or because other therapies were perceived as more efficacious.⁵⁴ Others may use different therapies without knowing it, as with the case of healers who are trained in two or more medical cultures—an African herbalist who also uses the tenets and remedies of homeopathy. Another motivation, however, is that so-called culture-bound syndromes seem to cross cultural boundaries in medically plural societies—a Zulu-speaker becomes anorexic, or an Indian acquires the illness of an *umtwasa* (an illness and initiation undergone by certain African healers). In such cases, the appropriate cultural practitioner, the one most likely to affect a cure, is sought out. For instance, Africans in Natal historically preferred biomedical practitioners to treat syphilis,⁵⁵ a disease introduced and associated with whites, while Indians often sought out Zanzibari or African healers in cases of alleged witchcraft.⁵⁶

Patients may also utilize other medical practitioners when compelled to do so by economic or legal necessity. The latter was certainly the case with indentured Indians on the sugar estates of Natal, African miners on the Reef, and, until recently, any South African worker hoping to claim medical aid or compensation. When medical pluralism is coerced through the dominance of one medical culture over another, as it was in South Africa, it can become problematic for several reasons. Although some medical concepts can resemble each other—for instance, Nguni notions of strong and weak blood are similar to biomedical ideas of the immune system—not all concepts are translatable.⁵⁷ This can lead to inappropriate treatment and frustration on the part of doctor and patient alike. The treatment may be ineffective or resisted if it does not fit within the cultural logic of the patient, for instance feeding newborns only breast milk seemed ludicrous to many African mothers at the turn of the century.⁵⁸ Likewise, this cultural gap has resulted in the current placement of persons experiencing symptoms of a *twasa*-initiate into mental institutions by biomedical doctors and patients' families who do not understand or recognize such culture-bound syndromes. When one medical culture (such as biomedicine) dominates and has legal privilege to enforce such decisions, as was seen in the Ngcobo case, other medical practitioners and therapies are by extension placed at a disadvantage in terms of their rights to practice and

gain access to state resources. Furthermore, the scientific resources dedicated to state-recognized medicine and the standards to which it is held put it at an advantage over those medical cultures that have not enjoyed the same scrutiny, in terms of both professionalization and regulation. This has been a complaint from both healers and AIDS activists, who note that the efficacy of antiretrovirals has been tested whereas the effectiveness of traditional medicines remains anecdotal.⁵⁹ Attention to the ways in which various communities understand health and illness could lead to more effective treatments as medical practitioners apply culturally appropriate treatments. Culturally bilingual practitioners who can translate biomedical ideas—such as HIV/AIDS prevention—into the appropriate cultural idiom may prove most successful.⁶⁰

SCHOLARLY APPROACHES TO AFRICAN HEALTH AND HEALING

African therapeutics has fallen largely under the scholarly domain of anthropologists, who historically have been much more interested in culture than have historians, who came to social and cultural history relatively late. Some of the first anthropologists in Africa synthesized the ethnographic-like writings of early European travelers and missionaries with their own observations of African societies. Later, anthropologists influenced first by structural-functionalism and more recently by the field of medical anthropology created monographs on singular cultural-linguistic groups—like the Kikuyu—or nation states—like Kenya—based on their own fieldwork. When seeking to contextualize their work in time, however, they tended to paint in rather broad ahistorical strokes. Those scholars who have examined medicine in Africa from a largely historical perspective have tended to focus primarily on biomedicine, inspecting its practice, influence, and utility for and during periods of white rule. Because the study of African therapeutics remained largely the province of anthropologists rather than historians, few works in the field have offered historical depth. There are a few notable exceptions.⁶¹ As a result there tends to be a wealth of synchronic evidence that offers up descriptions of initiation rights, accessories, the practices of African healers, and how such practices fit into the local cosmology. The appearance of information in isolated chronological pockets rather than examinations of change over time, however, necessitates studies that will determine the mechanisms and engines that drive transformation. This brief section looks at some of the major questions driving anthropological and historical research on African health and healing and colonial biomedicine and suggests ways in which this book both builds on and departs from previous scholarship.

Anthropologists of the 1930s and 1940s were very much interested in understanding why, after some fifty years of colonial rule and influence, many Africans still believed in witchcraft. While the assumptions of these anthropologists were highly Eurocentric—they believed that African culture would naturally give way to a more “rational” European one—their conclusions proved quite radical for the time. British anthropologists like Evans-Pritchard, Max Marwick, and Alfred Radcliffe-Brown argued that Africans were not irrational but used a different idiom in which to express their fortunes and misfortunes. They pointed out that witchcraft as well as other forms of health and healing related to ancestral interventions served very practical and functional purposes within African communities. Termed “functionalists,” such anthropologists demonstrated how these same phenomena sometimes created better social and community relations, instilled morality, and acted as economic levelers.⁶² Later structural-functionalists, such as Absolom Vilakazi (1962), Avel-Ivar Berglund (1976), and Harriet Ngubane (1977), sought to understand the internal and symbolic logic of witchcraft and African therapeutics. These authors placed particular emphasis on decoding the rituals and ritual props associated with African healers in order to understand the internal logic of local cosmologies. Unfortunately, the search for “authenticity” or African “tradition” led many early anthropologists to ignore the role of white rule. When mentioned, white rule served mainly as a backdrop that increased social, political, and economic stresses and consequently the number of witchcraft accusations. Cultural encounters between Europeans and Africans, let alone other groups, rarely served as the focus of such studies. The only early texts that directly addressed the impact of colonialism on African medical practices per se was a journal issue in 1935 that addressed the practicalities of colonial law and the rise in witchcraft accusations.⁶³ More recent work that has examined witchcraft and witchfinding movements in the colonial era emphasizes that the rise in accusations reflects African responses to colonial pressures rather than a resurgence of African culture.⁶⁴ Intercultural encounters are clearly at the forefront of this book, and this text utilizes some of the ideas of structural-functionalist analysis, particularly in seeking to explain the internal logic of chiefly medicines as well as functional aspects of witchcraft accusations, both of which will be discussed further within. It diverges from other works on witchcraft by examining the ways in which this phenomenon challenged not only European sensibilities, but also the rule of law.

In the 1960s and 1970s, medical anthropology emerged as a new field of inquiry that examined how social, cultural, economic, and political factors influenced the health and well-being of individuals within society. Such anthropologists looked at the influence that these factors had on the ways in

which people experienced and perceived illness. Working in Zaire, John Janzen (1978) asked how families and individuals made decisions to attend medical practitioners in a multitherapeutic community and why some illnesses seemed to affect only certain communities and not others. In Africa, studies in medical pluralism and culture-bound syndromes abounded during the 1970s and after, and like the earlier structural-functionalists they shared the idea that African healers succeeded based on their mediation of social conflict. Even today medical anthropologists still use the word *illness* to denote a nonbiomedical or “folk” construct, while the term *disease* denotes a biomedical construct.⁶⁵ This dichotomy drawn between biomedicine and other medical therapies implies that nonbiomedical diagnoses and therapies reflect cultural values and mores, while biomedicine remains largely divorced from culture, based instead on science. This is despite the fact that, like those of biomedicine, African diagnoses and treatments are based on careful observation and testing of remedies over time. The biological efficacy of traditional African healers’ remedies or practices, however, has largely been ignored by anthropologists even while gaining the attention of pharmacologists and venture capitalists. The result is a continued false separation between biomedical and nonbiomedical knowledge, much like the binary drawn by the judges during Ngcobo’s trial. Fortunately, more recent medical anthropologists and some historians of science have begun to challenge this dichotomy and show how “western” scientific research and interpretations also reflect the cultural background of the investigator.⁶⁶ Feierman points out that both are “forms of ethno medicine,” which “are embedded within a system of social relations.”⁶⁷ While this book does not presume to make judgments on the efficacy of specific African therapies, it does assume that African medical cultures have offered and will continue to offer many efficacious therapies that go beyond just a healing of the social and political body. Likewise the book builds off the work of both medical anthropologists and historians of science in its examination of the ways in which different therapeutic systems—African and biomedical—are culturally constructed.

Historical studies in health and healing in Africa and other colonized areas of the world have gained in popularity during the past decades. Such studies have increased scholars’ understandings of the complicated ways in which white rule operated and how it interacted with indigenous peoples. More importantly they have provided a historical context for many of the current healthcare dilemmas in postcolonial states today. Authors have approached such studies from a variety of angles, either by examining specific diseases (tuberculosis or syphilis in South Africa, sleeping sickness in the Congo, and black plague in Senegal), or by investigating certain healthcare providers (nurses

and medical aids in South Africa, midwives in the Congo or Sudan, and biomedical doctors in East Africa). Few, however, have written about healers. While it is rarely possible to group authors into distinct categories as scholars tend to utilize a number of different analytical tools, historical works on health and healing can be roughly divided into political economists of health on the one hand and constructivist historians influenced by the philosophies of Michel Foucault and Antonio Gramsci on the other.

In a seminal article Feierman urged historians to look beyond medical practitioners—African or otherwise—and their influence on African health and investigate instead the broader impact European colonialism had had on the health of the colonized.⁶⁸ Political economists of health thus examined how newly introduced epidemics and epizootics, the imposition of colonial legislation, and urban planning and industrialization affected and altered the health of Africans during the era of white rule. In addition to these larger structural factors, political economists have also focused on the availability of biomedical care to indigenous peoples and whether they have access to such care. Randall Packard, for instance, examines how the South African mining industry conveniently sent men home to the rural areas after they contracted tuberculosis in the mines and became unable to work. Not only did these rural areas lack the health infrastructure with which to diagnose and treat this ailment, but this move on the part of mine owners effectively spread this infectious disease to the countryside. Only when the pool of healthy, efficient labor shrank significantly did the owners invest in research and treatment of the disease both at the mines and in the countryside.⁶⁹ Although this is an important aspect of the colonial experience, it does not address the other ways in which medicine—biomedical or otherwise—shaped relations between the colonizer and the colonized.

Constructivist historians influenced by Foucault consider science and medicine another site for understanding power, particularly as it operated in the creation and imposition of political hegemony. This included the use of medicine as a blunt instrument of power as well as the power of medical discourse to influence cultural ideas of normality and abnormality, what is healthy versus unhealthy, sane or insane. When applied to the colonial context, historians focused specifically on how colonial biomedicine acted as a “tool of imperialism” that enabled the subjugation of African people and “legitimated” different forms of colonial legislation such as segregation.⁷⁰ Maynard Swanson, for instance, looks at how the emergence of bubonic plague in Cape Town in the early 1900s resulted in a medical discourse that linked filth and contamination to African populations. Despite a lack of empirical evidence to prove such connections, politicians used public health measures to serve segrega-

tionists' ends—to keep African populations out of the city. Megan Vaughan and Diana Wylie go even further in their investigations and examine the ways in which modern biomedicine constructed the “nature” of Africans within the colonial discourse, both culturally and physically. Such racial and cultural constructions sought to blame African political resistance to colonialism in East Africa on innate psychological disorders and African malnutrition in southern Africa on an African cultural obsession with cattle. Either way, biomedicine sought convenient answers that blamed Africans rather than imply a failure of colonial schemes or take responsibility for creating the condition of ill health.

Given the role that colonial medicine played in the implementation and maintenance of white rule, scholars asked why Africans would elect to use the very biomedical doctors and facilities that both alienated them and contributed to their oppression. By the 1940s many Africans (particularly those in the urban areas) had in fact begun to use biomedical services with greater frequency. Historians influenced by the ideas of Gramsci sought to understand how Africans consented to and collaborated in, but also influenced this aspect of the colonial project. Their attention turned to the role of African biomedical intermediaries—nurses, medical assistants, midwives, and doctors—who helped Africans to make sense of Western medical practices and practitioners. Whereas this scholarship deems colonial biomedicine an instrument of empire, it also sees it as a site of negotiation between African and European players. Shula Marks, for instance, emphasized how middle-class black Christian nurses not only coped with the frustrations of working with white racist doctors, nurses, and patients, but also were largely successful in convincing Africans of the efficacy of western medicine. Rose Hunt asks whether such adoptions reflect African belief in the efficacy of biomedicine as defined by the colonists, or whether perhaps Africans adopted biomedical ideas and interventions because they fit into their own cultural perceptions, local logic, and ideas of authority and prestige.⁷¹

While anthropologists have focused on African therapeutics, political economists of health and medical historians influenced by Foucault and Gramsci tend to tell the story of medicine and colonialism almost exclusively from a biomedical perspective. Few works have examined the impact of colonialism on indigenous forms of healing or the effect that indigenous therapeutics had on the practice and professionalization of biomedicine in the colonial context. This work uses the insights of anthropologists, political economists, and historians influenced by Foucault and Gramsci, but shifts the focus toward the historical interaction of multiple medical cultures and particularly the negotiation of traditional medicine by patients and healers. By re-aiming our

sights on African therapeutics and the way in which healers and patients interacted with biomedicine and Indian therapeutics, my work reveals not only the impact that colonialism had on local forms of healing but also the impact that local African therapies had on the practice and professionalization of colonial biomedicine. Consequently, I problematize what some scholars assume is biomedicine's colonial hegemony and add to the growing number of Gramsci-influenced scholars who emphasize the importance of negotiation between the colonizer and the colonized in the creation of hegemonic discourses and practices.

Though this study is grounded in the history of the Zulu kingdom and Natal, it has broad applicability to the histories of medicine and colonialism. This book does what few medical histories do; it looks at the history of an oral African medical culture over time.

(RE)CONSTRUCTING HISTORIES OF HEALTH AND HEALING

This book covers historical events and processes over a 120-year period that includes the early period of the Zulu kingdom (1820–79), the establishment of Natal, the colonizing of the former Zulu kingdom, increased urbanization, and the professionalization of colonial medicine. It was a period in which the noose of white rule tightened ever more snugly, restricting and radically changing African political, economic, and cultural life. The historical sources utilized for this book thus vary widely depending on the period, place, and subject. Such sources include European travel logs and memoirs; medical journals and books; the notes of medical councils and societies; anthropological studies and notes; government commissions, reports, and indexes; newspaper clippings; correspondence to and from the government; court records; the work of early African writers; oral traditions and testimonies of Africans recorded in the early twentieth century; and more recent interviews with African and Indian healers. Each source presents its own challenges and considerations, though all reflect, some more consciously than others, the time period and conditions in which they were produced as well as the individual concerns of the author or authors. Healers' lack of visibility in archival records and the ways in which Africans and Europeans described healers reflects their marginal legal position. Furthermore, cultural outsiders often used healers as a trope of African superstition, which they blamed for all troubles, from low rates of Christian conversion to the inability of the state to secure a stable African workforce. Below, I briefly discuss my approach toward reading and utilizing these sources as well as specific considerations for reconstructing histories of health and healing.

To determine the usability of evidence one must consider its nature, intended audience, subject matter, and the bias or agenda of the author. Reconstructing history for the Zulu kingdom is somewhat more difficult than for the colonial and later periods for which there are diverse sources. Almost all “precolonial” sources used in part I of this text were written or filtered by whites, and there are far fewer sources available for cross-referencing. Many of these earliest sources tell similar tales about the Zulu kingdom, reflecting not only the close interaction of settlers, but also the period practice of occasionally copying another author’s work verbatim.⁷² Port Natal settlers Henry Fynn and Nathaniel Isaacs, two of the most noted and cited accounts of the Zulu kingdom, had very distinct agendas. Fynn and Isaacs worked to open trade with the Zulu kingdom—particularly for elephant ivory and hippopotamus tusks—yet on losing their trading advantage and wearing thin the goodwill of their Zulu hosts, they began to advocate Britain’s annexation of Port Natal. Their writings thus sought to portray ruthless, tyrannical Zulu kings bent on destroying their neighbors, black and white. Isaacs wrote Fynn in 1832, suggesting how they should write about Tshaka and Dingane: “Make them out as blood-thirsty as you can and endeavor to give an estimation of the number of people that they have murdered during their reign, and describe the frivolous crimes people lose their lives for. Introduce as many anecdotes relative to Chaka as you can; it all tends to swell up the work and makes it interesting.”⁷³ Fynn, like many authors of the period, wrote his memoirs years after his experience in the Zulu kingdom and had his text possibly revised further by an editor’s hand.⁷⁴ Given such circumstances, a reader may wonder how it is possible to glean reliable information on a topic as potentially inflammatory as witchcraft and the craft of African medical doctors often described in the colonial literature as “witchdoctors.”

While obvious paternalistic and condescending sentiments are easily found in this early literature, there are moments and subjects for which precolonial authors were much more reflective and careful in their writings. White traders, missionaries, and travelers tended almost uniformly to view healers involved in sussing out alleged witches with revulsion and disdain, whereas African herbalists, surgeons, and bone-setters were viewed with curiosity and some respect and written about more objectively. This does not entirely prevent us, however, from learning important information regarding witch-finders. For example, when cross-referenced with other sources, Fynn’s insistence that those accused of witchcraft met an *immediate* and violent death appears as an exaggeration meant to vilify Zulu kings and chiefs. But despite his bias and erroneous claim that Africans blamed all illness and death on ancestors or witchcraft, Fynn demonstrates a nuanced understanding of

African belief in witchcraft and healing. At the 1852 Natal Native Commission he testified to a number of different types of healers, their gender, methods, and attire, and, in some cases, remedies.⁷⁵ Likewise, missionaries who wrote disparaging and exaggerated characterizations of witch-finders for a popular audience wrote other more realistic texts that attempted to analyze and understand the appeal of African healers and the hold that witchcraft had on African communities.⁷⁶

Many of these early writers offered rich details on health and healing as they sought to relate what they perceived as important historical events and details as well as cultural curiosities. Scholars Alexander Butchart and Osaak Olumwullah have recently argued that writers in the eighteenth and nineteenth centuries often adopted the language and approach of natural scientists in their depictions of Africa.⁷⁷ Their taxonomical gaze fell not only on the landscape but also on African bodies, and many became keen observers of African culture. Primary sources from this period are often punctuated with elaborate details of African looks, dress, beliefs, and practices related to African medicine. While most sources offer only fleeting observations of health and healing, a few, such as Francis Fynn,⁷⁸ Rev. A. T. Bryant,⁷⁹ and Rev. Callaway,⁸⁰ all of whom were fluent in Zulu, took a special interest in healers and wrote on the subject at length. Bryant's work *Zulu Medicine and Medicine-Men* perhaps best illustrates this genre as it was written as an "ethnological study of the Zulu people from the medical stand point" and published in the *Annals of the Natal Government Museum* in 1909. Bryant's information comes from his own early research on the Langeni people collected in the 1880s as well as the work of J. Medley Wood, curator of the Natal Herbarium in Durban from 1882 to 1913. Such "scientific" interests do not make this work less problematic, and Bryant clearly shows a certain disdain for African healers. He does, however, provide more information to cross-reference, as well as a rather detailed listing of medical applications and remedies.

Cross-referencing of sources is an obvious and essential component for determining the veracity of information about the past.⁸¹ While other texts confirm Fynn's claims that alleged witches were sometimes killed in brutal ways—including anal impalement—during Tshaka and Dingane's reign, they also show that execution was not necessarily immediate and that decisions could be mediated by other healers or changed by circumstances.⁸² Successful cross-referencing of course depends on the availability and quality of sources. To get a better picture and understanding of African medical practices and practitioners of this period I have included some sources outside the immediate area and period under study. Given that there are a number of regional similarities in African therapeutics, some of which will be discussed in

chapter 1, a case can be made for utilizing sources outside the kingdom, particularly from neighboring Natal. Since most Natal residents were Zulu-speakers, some from the kingdom itself and others who were never incorporated, Natal's Africans shared many linguistic and cultural similarities with those in the Zulu kingdom. I thus utilize some sources that reference the experience of Zulu-speakers from neighboring Natal during the period of the kingdom to verify and elaborate the existence of medical practices found in the Zulu kingdom itself. Similarly, although the nineteenth century was a period of rapid change, certain continuities in medical practices and beliefs persisted. When I find confirmation of such links, I utilize sources from the later period not only to demonstrate the maintenance of some of these practices over time but to flesh out some of the details that are not always evident from the earlier sources. I do not mean to imply by using such sources that all regional medical cultures are completely similar or that those of Zulu-speakers remained static. These cultures were complex and dynamic and regional variations are evident. Certain cultural resemblances and continuities, however, have clearly persisted over space and time. By corroborating neighboring and later sources with earlier primary sources about the Zulu kingdom, I can elaborate and add detail to some healing practices during the earlier period. Some of these later sources include oral sources of the kingdom recorded at the turn of the twentieth century.

Oral sources are an important means of accessing African perspectives on both the early Zulu kingdom and later cross-cultural interactions. These sources vary between oral traditions that tell origin stories of both humanity and the Zulu nation, oral histories that recall the interviewee's personal experiences, and records of narrators' immediate concerns, observations, and desires. Like written histories, one must consider the various influences on oral histories, considering the time in which they were recorded as well as issues of memory, bias, representation, and possible editing done by a narrator or recorder. Many African oral histories for the Zulu kingdom, for instance, were collected by and passed through white mediators. Not only did this mediation affect what information was imparted and how Africans imparted it, but the final recording ultimately reflected what the recorder and editor found of interest and worthwhile. To determine the nature and reliability of an oral text, it helps to consider the relationship between the narrator and the person or persons who collected and produced the final text. For instance, I utilize the collections of James Stuart, a colonial official in the 1890s and early 1900s who recorded many oral histories and also happened to be very interested in the history of the Zulu kingdom. His position and his fluency in Zulu tended to elicit both oral traditions of the kingdom as well as a number of complaints,

such as older men's frustration that the colonial government had forbidden the practice of rainmakers despite a persistent drought. Finally, much of the Stuart Archives, originally written by hand in Zulu and English, has now been published by Wright and Webb. This final production involved not only translations to English and explanatory footnotes, but selection by the editors of material they deemed historically useful. Clearly all of this influences the information the reader can glean from such sources. Furthermore, the narrative traditions describing the rise of the Zulu nation are especially diverse and cannot be treated unproblematically. This variety reflects the individual narrator's place of origin, family, religious affiliation, and the time in which the interview was recorded. The James Stuart Archives include nearly two hundred interviews from the turn of the twentieth century, most with African narrators—persons who made up the original core of the Zulu kingdom, those defeated and absorbed into it, and those who fled to the neighboring British colony of Natal. Groups that were politically marginalized by the Zulu kingdom tended to tell stories that emphasized the unnecessary cruelty of Tshaka, while core groups imparted more heroic narratives.⁸³

In contrast to reconstructing histories of the earlier period, the later history of European and African medical encounters can be traced more easily given the number and breadth of available sources. Some basic problems, however, arise from the criminalization and limited licensing of healers. Many healers and patients were reluctant to reveal information on the marginally legal and potentially taboo subject of health and healing. Likewise, many African and Indian healers were reluctant to obtain the required government licenses. Inyanga licenses were expensive and difficult to obtain, and Indians found their applications denied on the grounds that they were not Africans. Consequently, many inyangas actively sought to avoid the attention of authorities, and Africans and Indians fearing healers' retributive powers were reluctant to report them. As participants in an illicit activity, unlicensed healers left comparatively few archival records. The main exceptions are the very thick provincial and national files of applicants desiring legal recognition. Other than court records and the letters of a few elite healers, most of our archival and published information on healers for the twentieth century was generated by complaints of white pharmacists and biomedical doctors. Newspapers and memoirs sometimes described healers as cultural curiosities, and, as in the earlier period, certain observant colonial officials and missionaries left detailed anthropological information on healers and their practices. In many cases government commissions, blue books, court records, and memoirs, like many of these other sources, tend to come as synchronic snapshots. Cross-referencing and stitching together these various sources reveals a

larger story that enables us to trace both continuities and change over time and space.

Regardless of the period under study, all of these materials, despite and sometimes because of their biases, can be mined for different types of evidence. They can illuminate historical details; popular stereotypes and metaphors; or the concerns, fears, and desires of people living at the time they were recorded. Such evidence is expressed in either explicit or implicit terms. For instance, there seem to be few hidden agendas on the part of Africans or whites when describing the more “mechanical” aspects of Zulu public health; the same cannot be said for the much more controversial issues of witchcraft, “war doctors,” medical competition, and the use of human body parts in medicine. Yet stories of medicine and otherworldly power, told by both Europeans and Africans, can be read on a largely symbolic or metaphorical level. Sometimes Europeans are also rather explicit about their own concerns and intentions with regard to African healers, for instance, why the Natal government decided to criminalize healers. At other times incidental or implicit information is given, such as the sex of healers or the fact that healers formed their own military regiments at the end of the Zulu empire. This information is generally more reliable, given that it is not crucial to the argument at hand and may even contradict earlier information given by the same narrator. Clearly, familiarity with the various texts, cultural practices, and cultural tropes of groups, as well as the advent of historical events enables the reader to determine the nature of the evidence. Even with close attention to counterevidence and the ability to cross-reference many texts, there are certain gaps that cannot be filled from the written record.

To investigate some of these lacunae and discover how healers heal today, I conducted interviews with some forty healers from rural areas and small towns in KwaZulu-Natal and the city of Durban in 1998 and 2002. Though these interviews largely supplement and enhance the arguments in this work, they did help to fill in some of historical details missing from archival and published sources. For example, the historical interaction of Indian and African healers was one that was much better fleshed out through the use of oral interviews than through written documents. My interviewees represented a cross section of healers that included many different types of healers (inyangas, *sangomas*, *umthandazis*), both men and women, rural and urban, and African and Indian. The selection was not scientific but was done through various networks of healers, healing associations, and contacts of other researchers. The one continuity was that most healers belonged to a healing association of one sort or another and were fluent in Zulu. A good number of my interviews were conducted in English; however, over a quarter were

conducted in Zulu with the assistance of a translator who helped to ease my rough understanding of spoken Zulu. Given that healers have rather specialized and secret knowledge which understandably they may not wish to share with cultural outsiders, I informed each interviewee in the beginning that I was not interested in this type of insider knowledge but sought a wider understanding of how healers practiced within their communities and how they learned their knowledge. Interviews began with healers' descriptions of how they came to their calling, their families' background in healing, how they had learned their healing and medicinal skills, what types of illnesses they could treat, the general types of medicines and tools they used, and how they obtained such medicines and possibly from whom. In some of the interviews I showed historical pictures, mentioned names from the period under study, and showed various patented medicines as a means of elucidating responses.

Though the majority of the interviews were historical in nature, they, like all oral histories, were also inextricably tied to present-day concerns and reflected my own interests and my interviewees' perception of me as a white North American interested in traditional medicine. For instance there was a perceivable difference in some of my follow-up interviews in 2002 as opposed to the original conversations from 1998. The same persons who had been open and informal in our initial interviews proved much more formal and less forthcoming in subsequent meetings. The reasons for this are complex: a changed research environment that saw increased numbers of international researchers and students, a new national promotion of "indigenous knowledge systems," and the professionalization of local traditional healing associations, as well as some of my own changes. In a few instances, "individuals" I had grown to know gave way to healing-association "spokespersons" replete with talking points.

Given these connections between the past and present, let me say a quick word regarding the circumstances in which the bulk of these interviews took place, so the reader can gain some insight into healers' concerns at the time. In 1998 South Africa was experiencing massive urbanization; the HIV/AIDS crisis was beginning to be acknowledged publicly by government leaders, and the stigma of the disease remained quite high; the Natal Parks Board had begun to encourage healers to consider growing muthi gardens; and the prospect of legalizing traditional healers loomed in the near future. Such events and concerns provided a backdrop to the interviews, and consequently some healers implicitly and explicitly expressed concerns that included: fear of losing their "tradition" and hence the need to record their history, a desire to gain academic recognition for their craft, worry over the seeming proliferation of witches and witchcraft, awareness of the environmental impact of overharvesting of medicinal plants, and consciousness of the possible conse-

quences involved in the legalization of healers. Despite all of these more recent phenomena, when I asked healers how their own practices had changed, many claimed to practice just as their forebears had. Specific questions about types of medicines and how such medicines were obtained, however, showed that this was unlikely. I approached oral sources much like other types of sources: I looked for corroboration from both archival and published sources, as well as from evidence offered by interviewees themselves, such as photos, letterhead, and other cultural artifacts.