HEALTH, HEALING AND DIS-EASE IN A SOUTH AFRICAN TOWNSHIP.

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I gratefully dedicate this research
to the residents of Guguletu,
particularly those living in Section 3,
who went to so much trouble to help me
with this project.

"However much we laugh at miracles
when we are strong, healthy and
prosperous, if life becomes so
hedged and cramped that only a
miracle can save us, then we clutch
at this unique, exceptional miracle
and believe in it."

Solzhenitsyn (1968)

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CONTENTS

ABSTRACT

Intwaso is a condition which has been the subject of a great deal of psychological and psychiatric research over the past 50 years. Rarely have researchers rooted their interpretations within the social context, at either a micro or macro level. In this thesis it is argued that these omissions have resulted in a misunderstanding of the very nature of the process of intwaso. This project therefore aims to both remedy and re-approach a study of the condition by locating it within a range of other illness-episodes suffered by household-members. Secondly, a particular illness, tuberculosis will be used as a control in order to establish the social determinants of differing patient-family prophylactic measures and therapy-management. This is of central importance to an understanding of intwaso as some social contexts create circumstances in which ancestral possession is the explanation for successive illness-episodes and misfortunes.

An understanding of the social recognition or non-recognition of intwaso, the initiation into and functioning of a diviner-school is also of importance to an understanding of the process of intwaso. The schools are seen as being shaped in response to the structural stresses of living in a South African township.

The initial approach adopted in this thesis is to give a wide-angled "focusing shot" of the conditions and way of life of Guguletu residents, before honing in on a re-analysis of intwaso. The central tenet of this thesis is that without contextualization, a distorted interpretation of intwaso is inevitable, because the construction of the research design rules out the possibility of seeing the co-incidental nature of the condition.

PREFACE

> "The cure of a part should not be attempted without treatment of the whole. No attempt should be made to cure the body without the soul, and if the head and body are to be healthy, you must begin by curing the mind. That is the first thing. Let no one persuade you to cure the head until he has first given you his soul to be cured. For this is the great error of our day in the treatment of the human body, that physicians first separate the soul from the body."
>
> (Plato, Republic: 380 BC)

In the earliest days of western culture the priest and the healer were one. Man sought healing of his bodily sickness through processes of integration of the body and spirit and the temples were the earliest hospitals. It is only recently that specialisation has resulted in the roles of physician and priest being separated.

Plato wrote the above words in reaction to materialistic interpretations of Hippocrates' teachings. Hippocrates, the "father" of modern biomedicine, first taught his students the techniques of observation, examination, record-taking and deduction. He claimed that "to every disease there is a natural cause and for every disease a natural remedy". Before Hippocrates, disease and misfortune were perceived to be caused by the vexation of the gods or sheer bad luck, due to the position of the heavenly bodies.

This was the first attempt to control disease by altering the functioning of the human body, by means of natural remedies, especially herbs. His disciples down the ages, however, have taken the matter of allopathic medicine too far, by beginning to focus exclusively on the physical body. The wholistic concept of healing as expressed in the maxim "mens sana in corpore sano" (a healthy mind is linked inextricably with a healthy body), in many respects parallels the approach of the amaggira (diviners) who are ideally healers of social disharmony and disorder. As such they have an important place in an urban township such as Guguletu, a place, which although fraught with poverty, crime and disillusionment, has a remarkable range of organizations, created by the people themselves to cope with their problems. The amaggira networks are one of many other voluntary, supportive options, while also being part of a healing tradition which stretches across the length and breadth of Africa.

CHAPTER 1

INTRODUCTION : THE FOCUS OF RESEARCH

> "Patterned behaviour associated with illness in different socio-cultural contexts is embedded in fundamental premises pertaining to the nature of reality and of social relations. The study of such patterned behaviour is a means of understanding the structure of socio-cultural systems themselves."
>
> (Morsey S, 1980 : 153)

A central focus of this research project is for us to pursue this theme by tracing therapeutic networks of indigenous healers and patients, using recorded illness-episodes, as a "probe of social life" (ibid). This approach was adopted in an attempt to reveal some of the stresses peculiar to an urban "Black" population and to ascertain the extent to which membership or association with amaggira(1) networks plays an important role in assisting Guguletu residents to cope with their everyday problems. The range of these networks and the extent to which they are continuous with biomedical, indigenous healing agencies, independent churches and other supportive, voluntary associations will not be ignored, because amaggira networks are wide-ranging and incorporative in many instances.

The diviner networks which revolve around attendance at healing dance-seances (iinthlombe) must not be seen as an isolated healing method peculiar to "Africans living in the south of the continent". They are in fact part of a wide-ranging "Ngoma tradition" of both south and central Africa. "Ngoma" literally means "drum" throughout the Bantu-speaking area from the Congo coast to Tanzania, and the equatorial forest to South Africa. (Janzen, 1968:2) (2). "Ngoma" does not in fact mean "drum" in Xhosa, the word for drum being "igubu". The therapeutic nature of the Ngoma tradition, however, is similar in Southern Africa, while the root "ngoma" can also be traced linguistically in the Zulu word "sangoma", meaning "diviner". This lends support to Janzen's perception of the continuity of the Ngoma healing tradition in Africa. Interestingly enough, the Xhosa word for song central to the dance-seance, is "ngoma". Communication with the ancestral shades(3) is also a central characteristic of the rhythmic dance-therapy. The word "ngoma" is also used to apply to all relationships forged outside the family. It has been tentatively suggested by Janzen (1982, pers. comm.) that cows (iinkomo) used to forge

and legitimate social linkages may also be linquistically related to the root word "ngoma". Cows play a key role in the process of becoming a diviner (intwaso)(4), because sacrifice (5) helps to recreate harmony between both the diviners' novitiates, their family and ancestral shades.

> "The therapeutic meaning of Ngoma extends to include the rhythm, dance and song of the healing rite, as well as the corporate organisation and collective membership of those afflicted. Everywhere a particular Ngoma order is comprised of sufferers of a common affliction who, once they have gone through therapeutic initiation, become the order's healers to work with new sufferers much in the manner of self-help groups in the West....."
>
> (Janzen, 1982:2)

Although this thesis focuses on the patients and diviners within the urban township of Guguletu, the therapeutic networks used by patients who believe or are believed to be intwaso, extend beyond the Cape Peninsula as far as Zimbabwe and beyond. My actual fieldwork involved tracing networks within and out of Guguletu as far as Krwa-Krwa in the Ciskei. This appears to be the only manageable way to conduct research in an urban area (Agar, 1980).

The direct focus of this research will not be on the conditions of health and illness, but on the behaviour associated with conditions of illness and the resultant patient-family therapeutic management. It will, however, also be necessary to look at informants and indigenous healers' views of the nature and aetiology of some illness conditions, particularly intwaso. My research is directed at understanding the condition in an urban context.

It is assumed that the behavioural dimensions of illness will help to illuminate the social dynamics of illness-episodes, as well as an understanding of the indigenous explanatory models.

In general, research aimed to answer the following questions:

1. In what way their position in the social structure affects the Guguletu inhabitants' (a) expectations, (b) perceptions of health per se, and (c) their experience of the health care system?
2. Under what circumstances and for what reasons patients and their families decide to consult diviners in the urban context of Guguletu?

3. To what extent, given the broad range of medical options available (6) to patients and families, are indigenous healers, such as amagqira, popular in an urban society?

4. In what way and to what extent are diviners and their patients part of wider, supportive networks?

5. To what extent does the case material of illness-episodes bear out the specific problems of people who are classified as rightless sojourners in the urban areas?

An important aspect of this thesis is to show how a diviner-school is organised and how it functions. As Mr M said: "tell your people we amagqira are not untidy (negligent), we care for our people".

Amagqira are called by an initiatory illness (intwaso) which will be shown in some instances to be a form of passive-mastery in the sense that it has been used, for example, by Turner (1969 : 194) and Lewis (1971 : 25) who have analysed examples of spirit possession used as a coping strategy. Intwaso which is believed to be treatable only by amagqira will be studied in the light of what Lewis (1971) calls the essential "bread and butter question", namely: does spirit possession in an urban township relate to the social order? Secondly, how and why do amagqira fulfil their functions as social healers? It is also considered essential, however, to the understanding of intwaso to see this condition within the population's explanatory models (Kleinman, 1980) of health and illness as well as within the societal context.

Some of the social reasons for perceived intwaso, may be the same as they were in the past, but to understand indigenous illnesses such as intwaso and amafufuyana, in an urban area, they must be understood dialectically within the context of the urban social structure. It is not my aim to concentrate purely on indigenous illness episodes, but to see them within the context of a sampled range of episodes. In addition, the social context of aetiological decisions will be isolated in order to ascertain its determinative effect.

Perhaps it should be emphasized at the outset that amagqira, although focused upon in this project, are not the only non-biomedical healers used by people living in Guguletu. Iixhwele (powerful sorcerers), usually male

concentrate on healing by means of herbal remedies but are also capable of performing powerful feats by means of supernatural power. They are similar to amagqira, but are more powerful and capable of doing good and evil, according to informants. Iinyanga (herbalists) are also able to tell fortunes and to heal patients with herbal remedies, but unlike amagqira they do not have initiates nor do they participate at iinthlombe. In addition they are not believed to have supernatural power such as "giving luck to people facing criminal charges" or "helping children to pass examinations", as do both the iixwhele and the slightly less powerful amagqira. Faith healers of independent zionist churches(7) are also important sources of spiritual and physical healing.

It is important to realize that the roles of the above-mentioned healers, although discrete, may be filled by one person. Secondly, a single individual's network may overlap and encompass many of these institutionalized options.

It is possible, for example, for a female diviner to also fill the role of inyanga and to be a healer in a Zionist church (Ngubane, 1981 : 362). In the same way it is possible for a male inyanga to fill the role of the usually female igqira: Mr. "Golden" M. for example, a male inyanga and igqira, often wears an apron when he goes to dance at iinthlombe. He told me that the apron reminds him that when he is a diviner he must be "like a mother".

Therapeutic options are hierarchically organized by individual patients and families. Their choice of healer is made according to their perception of the nature and aetiology of illness. During the course of the illness, the decisions may, however, be altered. A repertoire of options may therefore be said to be used sequentially or concurrently during one particular illness-episode. A great deal has been written recently about patient-family management of therapy (which will be discussed in Chapters 4 and 5), for example: Ademuwagun (ed) (1979), Frankenburg and Leeson (in Louden (ed) 1976), Janzen (1976, 1978), Nichter (1978) and Kleinman (1978, 1980).

In order to (a) document therapeutic decision-making and management of patients, families or healers, and (b) ascertain what circumstances and illness conditions determine family-patient management and the referrals of diviners, it is essential to emphasize the broad, overlapping healing

networks, used selectively by patients. Some of the essential questions focussed upon are:

i) in what way patients and families perceived illness;

ii) how they explained illness and its causes;

iii) what they do when they are ill;

iv) which healers are chosen and on what basis their choice is made;

v) to what extent a range of healers are used during a single illness episode.

Overall, the ultimate aim of this thesis is to counter, to some extent, the many anomolies within western biomedical paradigms by approaching an understanding of the healing methods of indigenous healers. It is believed that psychiatry, especially what has come to be known as "trans-cultural psychiatry" (Fortes in Loudon, 1971), could benefit greatly in the South African context from an understanding of the wide-ranging options used by patients and families in their quest for therapy (Janzen, 1978). It could also extend the biomedical practitioners understanding of a patient's perception of health as well as his therapeutic expectations.

The research is now, however, orientated to the problems rooted in the bio-medical system itself. The approach is wholistic in that an attempt is made to situate medical systems within the structural constraints of South African society, thus the unit of investigation is health systems. According to Young (1978), medical systems and structural determinations together make up the health system. (See Chapter 2 for a discussion of these concepts).

It must, however, be added parenthetically that despite the need to avoid narrow problem orientation in one's actual fieldwork so that a wholistic perspective might be achieved, it is also necessary to ensure that useful applications to specific societal problems may be made by one's research. This project specifically aims to highlight problems within the sphere of public health standards amongst a Black population group. An attempt will be made to show, given that medical systems and structural determinants together make up the health system (Young, 1978), the Black populations experience of both the health care system and health per se, is directly

affected by their position in South African society.

Against the background of the political and economic conditions affecting the lives of Guguletu residents, an attempt will be made to re-approach an understanding of intwaso from a social anthropological perspective. In so doing it is necessary to root an understanding of the condition within urban township family life. It is also necessary to see intwaso within a range of other illness-episodes, in order to avoid isolating the condition and studying it within a vacuum. A narrow research focus has in fact resulted in a great deal of misrepresentation of this condition (see Chapter 5).

THE UNIT OF INVESTIGATION

The unit of investigation is the Black urban township of Guguletu in Cape Town. One may ask: why study only a Black population in Cape Town? What makes their therapeutic management of disease more interesting and researchable than any other section of the urban population? The answer is that although selective therapeutic-management and the choice of non-biomedical healers is not the preserve of Black African people in general, nor for that matter the population living in Guguletu, the inhabitants of Guguletu as a whole are subjected to very different living conditions as a result of South African classificatory legislation and the attendant statutes applicable only to Blacks.

I have established networks in Guguletu since 1979, which acted as a base for further research and enabled me to obtain case-histories and illness-episodes from this particular section of Cape Town's population. Fieldwork for this project was begun in Section 3 of Guguletu, which included a wide range of people from indigenous healers and their patients, to biomedically-trained nurses. I did not limit my network to healers and patients, but extended it to include a judgmentally-structured sample of Guguletu residents. This survey amongst other aspects showed the way in which residents perceived illness and health and what they did to prevent and treat sickness. Of the three townships, Langa, Nyanga and Guguletu, the last has the largest population of residents who qualify in terms of Section 10 (1) of the Black (Urban areas) Consolidation Act No. 25 of 1945 and are housed in the three-roomed standard family houses. There are, however, also a number of migrants housed in single-men's quarters in

Section 2 of Guguletu. It was important to include both migrants and those who have residential status in Cape Town within the unit of investigation, in order to avoid research-bias towards members with residential status who are therefore more secure, live in "better" conditions and have been urbanized for a longer period of time.

My fieldwork was not limited to Guguletu itself. In reality, networks extend far beyond the artificial limits of a unit of investigation, as mentioned above. Patients in their "quest for therapy" attend biomedical healers within the Peninsula but they also attend indigenous healers with great reputations far afield. According to Agar (1980 : 29), ethnography

> "involves a perspective of understanding of the human situation that does not require sharp boundaries."

It is necessary to delimit some tentative framework around a manageable area purely because a single researcher within a limited time can only research a circumscribed area, although an attempt was made to ascertain the range and extent of the diviner networks which criss-cross between the rural and urban areas. I did, for example, trace one of the migrant's networks back to Krwa Krwa in the Ciskei.

To summarize, we are investigating the social network building process of diviners and their novices as an important factor in coping with dis-ease. Secondly, we are interested in locating these networks within the overall repertoire of therapeutic resort, used by the residents of Guguletu. Thus the focus of this thesis is on patient-family (popular arena) and indigenous healer's (folk arena) prophylactic and therapeutic actions (Kleinman, 1980) seen within the overall health system. (See Chapter 2 for a detailed discussion of these concepts).

The igqira networks will be studied as one of the many coping mechanisms developed by Guguletu residents who, as members of the Black population group are most affected by their politico-economic position in South African society.

Thirdly, the therapeutic networks of Guguletu residents were not studied apart from the rest of Cape Town or outside their structural and historical context.

> "The question of "unit of study" far from being a methodological nicety, is a consequential theoretical matter. For fields of enquiry are never naturally given, they always reflect substantive assumptions about the constitution of the "real" world."
>
> (Comaroff, 1982 : 144).

The statement that anthropology cannot be separated from history has been made ad nauseum but the questions, "What anthropology and what history" are often begged (Comaroff, 1982 : 2). It is to these questions that I shall address my discussion of the theoretical approach central to the project.

The focus of research was shaped by seminar discussions, directed reading and fieldwork. As Agar (1980) pointed out, an anthropological approach to research propositions is not a process of testing their validity and encoding the results. It should be dialectical, initially involving fieldwork on the basis of which tentative propositions are formulated and then modified in the light of further accumulated material.

The emic-etic approach to guiding fieldwork, based on linguistic analyses of semantics conducted by Wright (1954), French (1969) and Frake (1962, in Lindzey and Aronson: 1968), is problematic, therefore its usage in the context of this thesis must be qualified (Janzen, 1982, pers. comm.) before a definition of the approach is given.

Firstly, a clear difficulty resides at the level of abstraction of semiotic reasoning. It has been accused of the sort of empty formalism of which Althusser's work has been accused:

> "Language becomes the decentered play of signifiers no longer having any referential relation to the real world."
>
> (Clarke, 1980 : 189).

I am therefore aware of the problems involved in making distinctions between the actor's emic, subjective level of meaning and the observer's analytical, etic level of meaning.

Secondly, where does one draw the line between the informant's point of view and that of the observer? How can one talk merely of opposing emic-etic levels when to a large extent the researcher draws heavily upon the informant's subjective views as a basis for his interpretive analyses? The

informant's views are in turn affected in many instances by the conversations held with the researcher.

In the context of the thesis "emic" and "etic" will not be used to imply an oversimplified relation between actor's and observer's levels of meaning, nor will they be regarded as being rigidly dichotomized.

The "emic" level will be used to understand the popular therapeutic and folk models (ibid) of a Black population, in terms of their own cosmological systems. This ethnomethodological approach aims to temporarily put aside or "bracket" all prior conceptions of the researcher, based on the emic biomedical perspective, needless to say it does not succeed entirely. An attempt was made to understand perspectives of illness aetiology, therapeutic decision-making and management from the actor's point of view. The "emic" approach can be said to focus on content and inherent meanings experienced and perceived by the informants themselves. In many respects this is analogous with Husserl's phenomenological approach to consciousness which involves bracketing and temporarily suspending the "taken-for-granted world-view"; in order that phenomena may be understood from an unbiased and fresh perspective, without too many preconceptions as to the essential nature of the phenomenon investigated. Although this ideal is never met in reality, it is a helpful approach in understanding the nature of indigenous illness conditions such as intwaso.

At the "etic-observer-level" of analysis an attempt is made to place meaning derived from the informant's model into the observer's explanatory model, with which the informant may or may not be familiar. This involves a translation from one level of understanding to another and it is therefore fraught with the possibility of error. It is also never apparent to what extent the observer's etic model is shaped by the so-called emic/etic model of the informant.

THE NATURE OF FIELDWORK MATERIAL

(a) Primary material consists of material derived from:

i) participant-observation of inthlombe and vumisa ceremonies;
ii) discussions with amagqira over a period of 18 months;
iii) informal conversations with people living in Guguletu over the same period of time;

iv) administering question schedules to 20 households in Guguletu for studying the social network-building process of the amagqira;

v) the transcription and discussion of tape recordings of iinthlombe. Comments made by amagqira and participants were particularly informative;

vi) discussions with amagqira and undergraduate students were stimulating, as in seminar situations many corrections were made by the amagqira themselves, to my interpretation of indigenous healing methods and the occasions for their usage.

(b) Secondary material consists of analyses of case-files, literature-surveys and discussions with biomedical staff members of institutions attended by patients.

According to Agar (1980) and to Frankenberg and Leeson (in Loudon, 1976), the only possible way to conduct a manageable project in an urban area, particularly if there is no reliable census data on which to base a random sample, is to trace out networks from a series of initial contacts. This approach was adopted in order to avoid the problem of limiting my research to a small number of informants who are not necessarily representative of a cross-section of the population.

The research method was not designed to hinge upon the information derived solely from structured question schedules. The formal interview technique tends to inhibit discussion and does not create rapport easily between the researcher and the informant. It also closes many avenues of research by forcing informants to give answers to particular, predetermined questions, some of which may be meaningless to the informant. In addition, when some informants realized that what they were saying was being written down, they became suspicious of the motivation behind the questioning. I therefore made it clear that their names were unimportant and that they obviously need not answer any questions which they preferred to ignore. Given, for example, influx control regulations, wariness of the rationale for research is hardly surprising. David Welsh (1975), for example, has pointed out the problems of research in a "divided society". In all instances I introduced myself as a student from the University of Cape Town who was interested in "what people do when they are sick in Guguletu". Usually this was regarded as non-threatening and people were happy to answer questions pertaining to illness, biomedical doctors, clinics and indigenous

healers. The only questions which were baulked at, related to residential status in Cape Town. For the abovementioned reasons, most of the questions based on schedules (see Appendix) were pursued in such a way that:

i) Questions were open-ended.

ii) Informants were encouraged to elaborate certain answers at length and ignore questions pertaining to pass status. (In fact no one refused to answer, but I suspect that the percentage of people interviewed without residential status is higher than was admitted to me).

iii) Discussions on any aspect of the schedule were encouraged, whether it was the price of rent in Guguletu, the difficulty of finding work in Cape Town, a Coloured Preference Area, or the length of time patients have to wait to see a doctor or nurse at the Guguletu Day Hospital; to mention but a few areas of concern.

iv) In many instances question-schedules were filled in after discussions, not during them, because of the inhibitive effect it had on some informants.

The households were structured to ensure that not all households had the same kinship structure, were similar in employment status or were of the same age-group. For example, some of these households were matrifocal with mothers, daughters and grandchildren living together; some were nuclear families consisting of mother, father and children; others consisted of aged parents and their grandchildren, or a core of two, kin-linked people plus lodgers, with or without residential rights. The economic range despite attempts to build in a variation, was not very great as not one of the families comprised only white-collar-workers. There was always a mix of occupations in each family.

The notes roughly jotted down during fieldwork were organized later and written up into a recallable format. Ideally the schedules which were administered to people living in family houses and shacks at the back of houses, should have been administered over about eighteen months, so that changes could be monitored in informants' responses to questions concerning the progress of illness-episodes. The time-dimension therefore had to be built in artificially (refer to Appendix I, Schedule I, Q.3). Despite the limited time-depth of the household schedules themselves, research involving informal conversations, discussions and participant observation extended over a period of eighteen months.

Because of the generality of the first two questions of Schedule I (see appendix) a certain amount of prompting was necessary. In some instances it was only when concrete illness-episodes were described that the actual problems of lack of work, low incomes, cost of transport and consequent inaccessibility of some hospitals were discussed by informants.

Collection of life-histories and illness-episodes was time consuming, therefore approximately 20 diviners, initiates and "almost-qualified-diviners", known as "five-to's", were consulted, as this was a manageable-number.

Schedule II (see Appendix) cannot be regarded as a comprehensive list of questions asked of the members of diviner-schools, nor was it referred to during conversations to a great extent as it tends to mar the quality of the material given during spontaneous conversation. Some of these informants were rurally based, and travelled to the urban areas to help fulfil the therapeutic requirements of patients. Others are urban based but visit the rural areas in order to fulfil the requirements of their patients ancestral shades. Ideally, I had aimed to have a sample of general householders and migrants outside any particular therapeutic context to provide a control for popular therapeutic management (Kleinman, 1980) involving amagqira. This was accomplished in the case of people with residential status: however, it was not always possible in the case of migrants as it was inadvisable, according to informants, for me to visit the barracks or hostels.

The sample of migrants was therefore skewed towards those who needed help, as many were met at the homes of amagqira as well as at biomedical clinics, simply because it was possible to meet them there. Migrants outside any particular therapeutic context were, however, also included in my house-to-house sample.

Although the unit of investigation focused upon indigenous healers as opposed to biomedical ones, doctors, nurses and other staff members were talked to informally at Guguletu Day Hospital and Valkenberg. This was done in the process of tracing therapeutic networks. One may query a focus limited to two institutions. The only possible response to this is that in tracing therapeutic networks of the people to whom I spoke in Guguletu, a great deal of time was spent at the Day Hospital. Valkenberg

Hospital, on the other hand, is the institution where I initially started doing a fieldwork project in 1979 and from where I traced patients' networks to Guguletu. I followed some patients' therapy networks by finding out which hospitals and clinics they attended in the Peninsula and speaking to doctors, nurses and social workers. In addition, I attempted to establish which indigenous healers the patient attended, many of whom are far afield, because apparently the further one travels to a healer, the more social prestige is gained due to the vast distances over which one's network extends.

DETAILS OF FIELDWORK AND RELATED PROBLEMS

It has been made clear by the above discussion that many difficulties are faced when conducting fieldwork in urban townships. Besides the legal restrictions in terms of Urban Areas (consolidation) Act of 1945, being female and White, limits free movement. The high crime rate in the urban townships was frequently pointed out to me by informants who warned me of the risks involved in doing fieldwork in Guguletu.

The second eldest son of Mrs. A.D., a diviner who is both a very helpful informant and friend, nicknamed me "Nethamsanqa", meaning "Lucky". This was regarded as a suitable nickname for an apparantly eccentric White, female who insisted on talking to a wide range of people in an area where "she did not rightly belong". Every initiate whom a diviner agrees to train must have a "special name". Mrs. A.D. calls me her "umkhwetha" in order to incorporate me into her network, and perhaps to emphasize the extent of her own, as she has met a large number of students and some staff-members at the University of Cape Town, when she attended seminars in 1980 and 1981.

Long discussions concerning the work of diviners were regarded half-jokingly as my training, but Mrs. A.D. and her novices did suggest that it was possible that I too would have to follow the call of my shades. Mrs. A.D.'s one and only male initiate assumed that I must be a novice because he had met me so often at the homes of diviners. When I denied it, he smiled knowingly at Mrs. A.D. She replied "Don't worry, you are right; Nethamsanqa is my umkhwetha, she just won't see it."

As a result of the unrest between the years 1976 and 1980, many people suffered. There are many commemorative occasions each year when Guguletu

residents have expected some sort of stand to remind people what happened in March 1960, June 1976 and June, July and August, for example. On such days I was always warned not to come into the location or to leave it if I was there, for fear that I was subjecting myself to unnecessary risks.

Mrs. A.D. and her network of amagqira always insisted that someone accompany me, usually one of their novices, to the outskirts of the township if we were attending an inthlombe in an area of Guguletu (or Langa) which I did not know well, to ensure that I did not lose my way. I was told: "There are always skollies in the location and you never know with them what they think of a white!"

Mr. C.G. also insisted on personally accompanying me to the rent-office to ensure that I had a proper permit: in fact, he followed my car to make quite sure, then accompanied me to the office. He feared that otherwise I would get into trouble, "because everyone must have a pass to show the police."

I am extremely grateful for the thoughtfulness of these amagqira. I found the effort made by Mr. C.G. particularly surprising at the time because at first he was very aloof. The fact that he filled the role of igqira made him feel obliged to provide supervision to anyone who consulted him. He claimed later that to be an igqira, a man must have the patience of a woman, which corroborated Mr. "Golden" M's opinion which will be discussed in greater detail below.

I was introduced by Sister I.M., a nursing sister at Valkenburg hospital who had previously helped me with a research project conducted in 1979, to Mr. C.G. whom she knew well by reputation. A patient whom I had helped at Valkenburg, by insisting that the social worker see her, introduced me to Mrs. A.D., who along with Mr. G., were my initial informants. The names of many of the informants have been altered or are not given in full, in order to preserve their identity and the diviner's professional responsibility towards their patients.

By introducing me to their initiates and allowing me to attend and participate in their healing activities, I was able to study their wide-ranging networks. Mrs. A.D.'s eldest daughter, L, introduced me, for example, to her friends and in-laws. As she is a qualified nursing sister, her networks of associates included nursing sisters and other matriculants.

As it was inadvisable to go to migrant hostels, I made an effort to meet migrants in the house-to-house survey and at the homes of Guguletu residents. For example, Mr. C.G., who is consulted by a very large clientele of migrants, allowed me to use his yard, where under an open shack, large numbers of migrants sat discussing their reasons for coming to have their fortunes told. With the help of the introductions made by Mr. C.G. and his brother's son as well as their aid in translating, I was able to collect material on perceived illness and misfortune.

Communicating with many people in Guguletu is possible by using English, Afrikaans and a limited amount of Xhosa. I registered for the Xhosa-Service Course offered at the University of Cape Town, in order to learn the language. Attempting to talk Xhosa to the informants went a long way in creating rapport. Both Mr. C.G. and Mrs. A.D. were adamant that only by trying to learn the language would I be able to understand "their people". Language was always a good starting point for conversation. By asking the meaning of words, one often received helpful insights into informants' cosmology. A limited understanding of the language also made it possible to understand to what extent I was welcome.

I relied on translations made by healers for my benefit during the healing ceremonies themselves and on transcribing tape-recordings with the help of informants. Sister I.M. was a very helpful translator, as were Mr. C.G. and Mrs. A.D. and many other people who clarified what was being told to me by informants. Some informal conversations with diviners and their novices were also recorded so that I could listen to them repeatedly, thereby gaining a greater understanding which would provide me both with insight and leads for further questions. Mrs. A.D.'s son, A. once said: "Janet, you are always asking questions and more questions. Don't you get tired of this igqira-business!" I often marvelled at how seldom my informants became tired of answering my probing questions! On occasions, tea parties for Mrs. A.D. and her novices were held, either at her home or at my own. At these gatherings, the general customs (amasiko) of the diviners were assiduously discussed in an enjoyable, relaxed way. V. and F., two of Mrs. A.D.'s novices, were extremely amused that I had imphepho flowers on a table in my sitting-room. These dried, yellow flowers are used as a type of incense by diviners particularly during iinthlombe. They teased me that this was proof that I "truly wished Mrs. A.D. to train me to become a diviner."

More formal seminar sessions were held with Mrs. A.D., her novices, fellow diviners and the first-year occupational therapy students during 1980 and 1981. Mrs. A.D. and particularly her sister, E, who is also an igqira, carefully explained their explanatory models (Kleinman, 1980) for illness and the rationale for therapeutic management in particular social contexts. As a focus for discussion I showed slides taken at the iinthlombe to which Mrs. A.D. and some of the members of her network were invited. Mrs. A.D. who is an extremely helpful friend and informant adroitly converted knowledge of daily occurrences into answers to questions requiring considerable abstraction and command of English. It was not difficult to establish rapport with Mrs. A.D.'s network, because I found her an extremely patient and helpful person for whose intelligence I have great respect. I attempted to reciprocate her eagerness to explain healing methods and her introduction to her network by trying, for example, to have her mother's pension, which could only be payed out in East London, transferred to Cape Town where she had moved in order to be with her family.

I was incorporated into Mrs. A.D.'s group of diviners by being given an "Umkhwetha name" and ensuring that I knew a song, which Mr. "Golden" M., one of her peers taught me, so that I would be able to participate at iinthlombe. She also lent me her blanket and stick, insisting that I use them so that I would not be "out of place" on these occasions.

Mr. C.G. and his novices were not as easily befriended. For many months he called me "intombazane" (young girl), not even "intombi" (girl), although he was superficially polite and helpful. It was after he had become used to my visiting and seen my photographs from the Ciskei of healing ceremonies that he became interested in helping me. In June, 1981, I had spent some time at Kwra-Kwra and Upper Nega where I attended a sacrifice of a cow to the shades (loosely translatable as "inkomo yezilo") by a migrant who was working on contract at Koeberg Nuclear Power Station.

After Mr. C.G. had seen the extent of my own networks he agreed to allow me to attend his vumisa (fortune telling) ceremonies and patiently explained during the intervals between each vumisa session what had occurred. Often as many as five groups of people came to consult him on one morning.

During the eighteen months' period, I engaged in extensive participation at iinthlombe and vumisa ceremonies. As mentioned above, I tape-recorded some

of the proceedings. I did not, however, suggest taping any of Mr. C.G.'s vumisa sessions as I felt sure that he would not agree. There were no heated objections to my use of a tape recorder at the iinthlombe, in fact some of the participants became annoyed with me on one occasion when I had neglected to bring it. Listening to the singing and praying was found most enjoyable by participants.

In order to attend an entire healing ceremony held over the week-end, it is necessary to stay until about 3 a.m. on Saturday morning and to return at about 12 o'clock the same day. Everyone attending the iinthlombe sleeps there overnight, feasts, and continues to dance at midday. The dancing continues until late Saturday night and on Sunday the iinthlombe ends at about 6.30 in the evening. I was told to ensure that I was accompanied, as Mrs. A.D. warned me that her amagqira would not understand my behaviour, because to be alone at that time of night would be to show no respect, "hlonipha", as a young woman should.

It was only after I had conducted informal discussions with people in section 3 and had an idea of what questions to ask, that a schedule was drawn up and administered to 21 households. As mentioned above the administering of schedules even if used informally as a guide to conversation, was not ideal for conducting research. One of the main problems was that it was impossible to talk to people individually. Householders contradicted one another, filled in gaps in one another's stories, while friends and lodgers added more information. There was no attempt to provide privacy for what I would have regarded strictly personal information. Illness and misfortune are the concern of families and all relevant others; they are not only an individual concern as in "white middel-class western" society. Members of Mrs. A.D.'s family, who knew most of the people in the area, disagreed with some of the information others had given me. It was found that some informants, for example, did not reveal that they had families in shacks in their backyards. It had been frequently announced by police over loud-speakers that the shacks had to be cleared and pulled down or they would be collapsed by the police. This is just one example of the source of bitterness and anxiety of informants, who were surprisingly willing to talk to me about most non-threatening topics which did not, for example, touch on sensitive areas such as pass-status. Other householders were more trusting and claimed to have as many as 16 people using the

facilities of one three-roomed family house. An informant complained, "How are we expected to keep well when we are so packed together that even old people must sleep on the kitchen floor?"

Mrs. A.D.'s entire nuclear family is well-known to me as are quite a few members of her extended family. Her neighbours' lives, and in fact most of the people who live in her street, are familiar to her. Although never willing to gossip about people she respected, she was always willing to explain the general outlines of the illness-episodes of people within her network. She, however, always insisted that I speak to them myself, if I wished to find out any details. This ensured that she would not be found guilty of gossiping, which is considered unethical for an igqira. People outside her personal network, whom she did not respect, were not shown as much consideration as they were considered unworthy.

Much detailed background information about township life was obtained from a field researcher at the South African Institute of Race Relations who lives in Guguletu, as well as from students from the University of Cape Town who live there.

FOOTNOTES

1. Refer to the glossary for definitions of all Xhosa words used in the text.

2. It is Janzen's aim to compare and portray the Ngoma institution in Africa as a whole.

3. After the distinction made by West (1975)

4. An indigenous condition associated with possession by ancestoral shades. See Chapters 2, 5 and 6 for detailed discussion and the glossary for a more complete "definition".

5. Sacrifice of cows marks the novice's progress in the training-process, because at each new phase of initiation one or more cows, depending on their interpretation of the will of the shades, is sacrificed. Cows are therefore symbolic of the forging of links, harmony and the oneness of man, fellow man and his ancestral shades (See Chapters 4, 5 and 6). The sacrifice can also be understood as a means of redistributing economic resources amongst the novice's extended family and diviner network. Cows can be seen as both economic inducements to belong to a network while also being symbolic of the unity of its members. By extension cows are also symbolic of health, wholeness and wealth (see Chapter 6).

6. Refer to Chapter 2, pg. 23 for a discussion of the unethnocentric way in which the concept, pluralism, has been interpreted.

7. Faith healing in African Independent Churches has been documented by Sundkler (1964), Daneel (1970) and particularly West (1975).

CHAPTER 2

THEORY AND CONCEPTS CENTRAL TO THE PROJECT

Chapter 2 is structured in answer to the question posed (Chapter 1, p.10) namely, what anthropological approach and view of history is being used as a framework for research? This is followed by a discussion of fieldwork methodology and associated problems.

What Anthropology?

Medical anthropological theory has only developed as a sub-discipline of social anthropology since World War II. It has its roots, however, in the work of earlier anthropologists such as Rivers (1924), Sigerist (1951), Audrey Richards (1932), M. Read (1932) and Evans Pritchard (1935), to name but a few. Despite attempts to emphasize that medical anthropology is a field apart, it has only been developed and extended as a result of direction and criticism given by main-stream anthropologists and to a large extent by sociological perspectives provided, for example, by Navarro (1976), Savage (1978), Young (1978), Janzen (1978, 1981) and Comaroff (1969), to mention some representative examples.

To a certain extent an attempt is being made to break the previously carefully maintained disciplinary boundaries and to bring some coherence to the theoretical positions posed by sociologists and social anthropologists. Kleinman (1978 : 85) at a conference directed at just such a purpose, attempted to put forward a cohesive theoretical model which he had used as a basis for fieldwork and asked members to treat it as a basis for discussion:

> "The task assigned to me was to examine theories and concepts that can be used to compare medical systems as cultural systems. Review of the relevant medical anthrolopoligical literature, in preparation for writing this paper, revealed, with a few exceptions, a paucity of well-developed theoretical positions on this subject which could be neatly summarized, compared and contrasted. Instead, most of the literature is taken up with empirical studies that usually do not specify the theoretical frameworks they employ, that unsystematically import concepts from social science of biomedicine, and that, as a result, are fragmented and difficult to relate. We possess a large array of empirical descriptions, but few cross-cultural comparisons, and hardly any attempts to test specific hypotheses. Here is evidence of the lack of a theoretical base which is the reason for holding this conference."

According to Fortes (in Loudon, 1976) early anthropologists were preoccupied with ethnomedicine, itself, just as much as some modern anthropologists. Others are concerned purely with research designed to improve so-called Western bio-medical programmes. This is problematic as it is essential for a social anthropologist to stand aside from biomedicine or to bracket it, to use a phenomenological term, in order to avoid the usage of our own "emic" views of medicine to understand and explain folk models (Kleinman, 1980).

In addition, both these approaches err on the side of dualism because they see medical systems outside their structural determinants. This is analytically unproductive, as are all liberal analyses which seek to examine particular social phenomena, without ascertaining their dialectical relationship with other social dimensions. It is only by looking at medical systems wholistically within the context of politico-economic determinants that useful insights into the wide-ranging health-system can be gained. In other words, to analyse medical systems per se is an unproductive level of analysis. Young (1978) quotes Kunstader's (1975) definition of health systems as follows:

> "aspects of behaviour and technology which, in the interaction with the environment and the population, influence the health of the population."

When so-called "Western Biomedicine" is seen out of context it is reified as being responsible for all its faults, for example: Illich (1975) and Zola (1972) describe how medicine itself is the monster solely responsible for its own nemesis. Illich's conclusion can be criticized in the light of Navarro and Young's (ibid) analyses, as they see politico-economic determinants as the causal factors affecting the health system which will be the unit of analysis in this thesis.

Another theoretical bias which I shall seek to avoid is a concentration on "health care delivery" and the "consumer aspect" as this is also an inadequate unit of study for the abovementioned reasons. It is important to look, wholistically and dialectically, at the dimensions of health itself, that is, perspectives of health, prophylactic measures and self-help (vide Dean, 1981); not merely at therapeutic management and health-care.

The phrase "plural medical context" needs to be explained precisely at the outset in order to avoid misinterpretation of its meaning in the context of this thesis. The phrase was originally introduced to the body of medical

anthropological theory by Charles Leslie, after he had conducted fieldwork in India to refer to the many different types of therapeutic options available to patients which were selectively included in their repertoire of resort. It has been applied to distributions of power in ethnically heterogeneous society, but this aspect of meaning is not included in the way in which Leslie originally used the definition. It is not my intention, however, to subtract any political connotations from the term, but I do not wish my use of "plural" to be confused with the sense in which it is used in some liberal-dualist analyses of South Africa.

Comaroff, Roberts and Young (1981) emphasized the problematic nature of "pluralism;" however, Roberts' suggestion to replace it with "multi-dimensional", was counterproductive, because the problem of inter-relatedness of socio-political structures and the plural medical context remained.

Because of the pluralistic nature of options, it is necessary to focus on the perspectives and behaviour associated with the choice of healer, the reasons for his choice, and the expectations of the success of treatment. Frankenberg and Leeson (in Loudon, 1976) point out that Horton's (1975) contention that "African medical paradigms are closed" is entirely erroneous. Nor is support for Horton's conclusion found when considered in the light of the pluralistic therapeutic-management of Guguletu residents who regard all medical options as being part of the one repertoire, as opposed to seeing them as competitive systems. We are not, therefore, interested in studying the boundaries between medical systems, because we cannot consider medical systems monistically unless we wish to look at "tight little, right little" medical systems (Last, 1981) which have no correspondence with the way in which multiple options are used by Guguletu residents.

Brief outlines of concepts central to the theoretical approach will be given so that their meaning will be made explicit in the context of the thesis.

1. Indigenous is the term used to refer to the Amaggira and their healing methods. "Traditional" will not be used because of the negative connotations in meaning underlying it, such as "backward" and "ineffectual" (see Schweitzer, 1977). The term indigenous healer does not apply to all non-biomedically trained healers, as it was pointed out when discussing the unit of investigation, because many categories of healers exist which cannot be described as purely indigenous. Faith healers and fortune tellers are just as much part of other so-called population groups' belief systems as they are part of the indigenous cosmology. The term is therefore purely one of convenience.

2. Biomedicine. All medical practitioners working within the disease model characteristic of allopathic medicine will be termed biomedical practitioners. According to Comaroff (1980 :10):

> "The biomedical model implies that both the form of aetiological hypothesis and the nature of therapeutic intervention is not located within the ecological context."

Thus a discontinuity exists between the individual and the rest of his family, and society. The biomedical system, as a unit of investigation, is avoided because it does not situate medical systems within the structural constraints of South African society. Health systems, defined above as medical systems plus structural determinants provide a more wholistic and realistic picture.

3. Health. The word "health" in the English language is a wide-ranging term used relativistically. One can be healthy despite having "a cold" or some other minor ailment. According to Frankel (1981 : 23),

> "Health is thus a state of resilience, a state of comparative invulnerability to disease."

The World Health Organisation's charter contains another definition of health as being:

> "A state of complete physical, mental and social well-being, and not merely the absence of disease or imfirmity."

But this definition is still inadequate as one has not yet defined "well-being", a value-laden concept. Standards of well-being are socialized and vary according to society's expectations. The value-content of health is implied in the etymological root of the word health. "Wholeness", is a moral more than a medical concept.

A Christian definition of health given by John Wilkinson illustrates this:

> "That man is healthy who is in a right relationship with God, with himself, with his neighbour and with his environment."

In other words, health and wholeness are the essence of holiness.

Healing as far as the amaggira's philosophy is concerned, also aims to restore relationships which are disrupted and tension-filled. Their maxim drawn from African philosophy is "To be is to participate". Without the existence of a balance between man, nature, his fellow man and his izinyanya (ancestral lineage-shades)(1), health is believed to be unattainable.

Boorse (1977) however, attempts to order the large number of different perspectives. He does not see health as a relativistic concept, but rather as a value-free theoretical notion. He defines health as the absence of disease, provided that one's conception of disease requires no value-judgment about what entails universal malfunctioning of the body:

> "apart from universal environmental injuries, diseases are internal states that cause a functional ability below species typical levels. Health is defined as freedom from disease within statistical normality of function, the ability to perform all typical physiological function with at least typical efficacy; this conception of health is as value free as statements of biological function."
>
> (1977 : 542)

He avoids the issue of what, for example, is termed healthy by a population group who for either politico-economic or environmental reasons, regard disease as being normal, by arguing that there are as many dimensions of popular health as there are of disease. This issue is not relevant to this thesis, however, as all residents of Guguletu share the same health aspirations as the rest of the population of Cape Town. The relevant question is, to what extent it is possible for them to achieve these aspirations?

4. Disease, illness-episode, illness, sickness and dis-ease. The distinction has been made between "disease", a pathological concept, "illness", a subjective, personal concept and "sickness", as the sociological recognition of perceived illness, by for example, Anderson (1978), Young (1976) and Frankenberg and Leeson (1976). For analytical purposes these etic distinctions are useful. They do not, however, correspond exactly with emic popular and folk categories of people interviewed, for instance: illness and misfortune are often collapsed into a general illness category by amaggira. Illness-episode will be taken to mean

one subjectively recognized period of illness.

The hyphenated word "dis-ease" is used in the broadest, descriptive and incorporative sense, not as an analytical term. Dis-ease when explained in allopathic terms of abnormal biological functioning becomes devoid of social or ethical meaning-content, which the individual is able to comprehend. It is in "pluralistic medical contexts" that one is able to establish the differences, similarities and continuities between biomedical and indigenous paradigms.

5. Areas of Health Systems. According to Kleinman (1980, 1978 : 86):

> "Most health systems contain three social arenas within which sickness is experienced and reacted to. These are the popular, professional and folk arenas."

Within the popular arena, prophylactic measures are carried out and, where necessary, patients and families consult their network as to which healing agency to choose. According to Kleinman (ibid), between 70 and 90% of sickness is managed at this level. At the popular level, there are certain expectations and evaluations of treatment of which a researcher must take cognisance in order to understand an illness condition such as intwaso.

Until recently, the popular domain was not studied, instead the folk domain was over-emphasized. This domain comprises the so-called indigenous healing methods. Kleinman's interpretation of the professional domain consists of biomedicine and professionalized indigenous healing methods, such as chiropractors and acupunturists, for example. Under no circumstances do I use the distinction between the folk and professional domains in an ethnocentric manner, suggesting that one domain is "better" than the other. It should also be emphasized that in quite a few instances, folk healers are professional in the sense that they spend all their time working as healers and can only practise once they have qualified. The distinction between folk and professional is thus used, minus any detrimental connotations, for purely heuristic purposes.

Each of these sectors has its own explanatory model. The focus of my research is the popular and the folk explanatory models of intwaso in particular, not on the explanatory models of biomedicine. In order to understand popular and folk therapeutic-management, it is essential to have, at the outset, a brief outline of indigenous African cosmology, as much discussion revolves around the continuum of personal and impersonal types of causation, which have been artifically separated by many anthropologists.

Misfortune and illness are not seen to be mutually exclusive categories. Family management of therapy is thus the same for perceived misfortune as it is for unnatural illness. Illness is perceived to be either natural or non-natural. Natural illness "just happens" and consists of colds, toothache, childhood illnesses, minor wounds, and the ageing process, for example. Non-natural illnesses, however, are symptoms which are interpreted within a particular social context, as having "something behind them", that is, some specific, intended meaning.

As mentioned above, to be healthy in mind and body, one must be at peace with oneself and one's family, fellow man and shades. The patrilineage system extends beyond the barriers of death and ancestral shades are regarded as seniors who continue to intercede in the affairs of their descendants. The word "shade" will be used in the sense that West (1975) used it to refer to their perceived effect on the lives of their descendants.

In day-to-day living they are usually referred to in the plural as "izinyanya", a corporate undifferentiated body (see Chapter 6), although the ancestral shades with which they are familiar are also named individually in ritual situations. It is believed that if the harmonious balance between society and nature is upset, either by the izinyanya turning their backs upon their descendants, who morally deserve to be neglected and unprotected, or by the undeserved, immoral actions of an igqira (witch). The lineal shades do not neglect their descendants without a reason, and therefore they are never blamed for misfortune although descendants exhort or berate them not to be neglectful.

In the social contexts where it is suspected that the balance between man, society and nature is upset and that there is a reason behind the cause of the physical or psychological symptom, the aid of an igqira or another social and spiritual healer is sought.

By focusing on the social context of illness-episodes, one is able to establish under what circumstances patient-family therapeutic decisions are made to consult an igqira.

A cursory outline of theory pertaining to intwaso and informants' definitions is necessary as a basis for further discussion. Intwaso is derived from the verb "ukuthwasa" meaning literally "to come into view or to commence" (Lamla, 1975). It is applied to the phases of the moon and the seasons and has the implicit meaning, when applied to a perceived illness condition, "of being in the process of a change in role, status and identity under the guidance of the shades".

Intwaso has been studied as an illness decontextualized from the range of patient-family therapeutic decisions for illness-episodes. It has been studied, for example, as a category of illness by Schweitzer (1977); as a descriptive term for a group of characteristic symptions by Hunter; and as being equivalent to schizophrenia by both Laubscher (1937, 1975) and Kruger (1981), for example.

It will be argued that the problems associated with the above works, including those of O'Connell (1982) and Soul (1974), stem partly from decontextualizing a study of intwaso from 1) a wide range of other illnesses, and 2) family and social structure, thus making it impossible to study the social determinants of aetiological decisions and therapeutic management.

Briefly, intwaso is considered by informants to be the initiatory illness of diviners, sent by the ancestral shades. Umbilini, a feeling of uneasiness and rapid heart-beat, accompanied by pains on the right hand side, the woman's side as well as culturally-patterned dreams, are the symbolic symptoms always associated with other non-specific problems in cases of intwaso. It will be shown that intwaso is the idiom used for the post hoc explanations of perceived misfortune and illness. The popular and folk aetiology of amafufunyana (an indigenous illness condition)(2) on the other hand, results from the believed sorcery of an ixwhele (powerful sorcerer), who usually works on behalf of some-one with a grudge against the victim. The ixwhele is consequently feared as he is believed to do both bood and evil. The ixwhele is believed to possess his own amafufunyana who obey his will and therefore make him more powerful. Amafufunyana themselves are described as "little fighting men", perhaps in the same way

as a layman would describe germ-theory. Amafufunyana is contracted when the ixwhele, having drawn "dirty things" from graves, blows them in the direction of the victim. Once inhaled or swallowed, they cause fits of violence and strange voices are believed to be heard coming from the victim's stomach.

If not treated quickly, the condition is believed to deteriorate into madness (phambana). Intwaso, if ignored, also deteriorates into phambana. Thus phambana is seen emically to be caused either by immoral victimization or by ignoring the call of the izinyanya, who wish the sufferer to become a diviner. As it is a call from the ancestors, it is regarded as moral as opposed to immoral. Phambana is, however, also believed to be naturally caused, for example, two children in my sample of households were described as "just not right in the head". In fact, all symptoms may be interpreted as either natural or non-natural, depending on the sufferer's social situation and the perception of the latter and his family. Many illnesses are also considered as having multi-faceted causes.

The distinction between natural and non-natural notions of African causation has been over-emphasized, according to Janzen (1981 : 78), Horton (1975 : 169) and Gluckman (1955). If one examines monographs such as "Witchcraft, Oracles and Magic amongst the Azande", one realizes that even when witchcraft was seen as the primary cause, or was highlighted in a particular context as being the most relevant cause, natural explanations were not ruled out.

B. What History?

> "The existence of value and action in time involves both their (societies) perpetuation and transformation and understanding the relationship between the two in particular contexts is a central problem, for the study of therapeutic systems, and any other. This entails by extension, examining how processes of reproduction and change are shaped, both from within and in relationship with external forces. I stress, however, that such a program does not merely entail recognizing the new widely made plea for a symthesis of history and structural dimensions of socio-cultural dimensions of socio-cultural form, it requires that we specify what kind of history and what view of structure is appropriate to the enterprise."
>
> (Comaroff, 1969 : 368).

The historical approach used for this project is materialistic, but emphasizes:

1. Humanism, the creative potential of human being, which is stunted but not entirely alienated as Althusser believed, under capitalism.

2. Historicism, or the belief that knowledge being based on socially-mediated experience and being validated through social practise, is necessarily the product of social conditions at a particular time and place, conditions which are historically relative and which can be changed by those who live under them.

These crucial elements, rejected by Althusser et al., will be included as without them, "one dimensional Marxism" (Clarke et al., 1980) is the result. The latter is an over-simplistic historical approach as it dismisses the abilities of mankind to either change or cope with the nature of social reality.

Althusser's anti-historicism and anti-humanism was due to his defence of "the autonomy of the dialectic" over historical materialism and so of philosophy over politics (Clarke, 1980 : 14). Consequently, politics is restricted to a superstructural level and culture is seen as being separable and separate from the economic base. He begins with the assumption that there are three or more separate levels in the social whole, and the next step was to concentrate purely on one level (Clarke, 1980 : 179).

One cannot merely say that economic base affects the superstructure or that the superstructure affects the base: all dimensions are fused in reality. Any discussion of separate moments is a theoretical, heuristic device, a simplification of the whole. Of this Marx was aware, but his disciples reified his theory and the results are less than useful (3). Thus the materialist approach to history used in this thesis is clearly not Althusserian.

The background of how and why Guguletu was located in the Cape Flats will be given, in order to avoid looking at:

1. the social-network building process of diviners and their initiates as a means of coping with day to day living requirements, and
2. the repertoire of therapeutic resort used by Guguletu residents in an historical, political and economic vacuum.

In so doing the social engineering of their removal will be made clear. In addition, the political and economic factors affecting their every-day lives will be outlined. In order to present a living, meaningful and moving picture, I shall use personal accounts of informants to flesh out the only too familiar politico-economic restrictions. Thus discussions of patient-family therapeutic management and the use of diviner networks will be firmly lodged in the societal context of health systems, with particular emphasis on the popular and folk domains.

FOOTNOTES

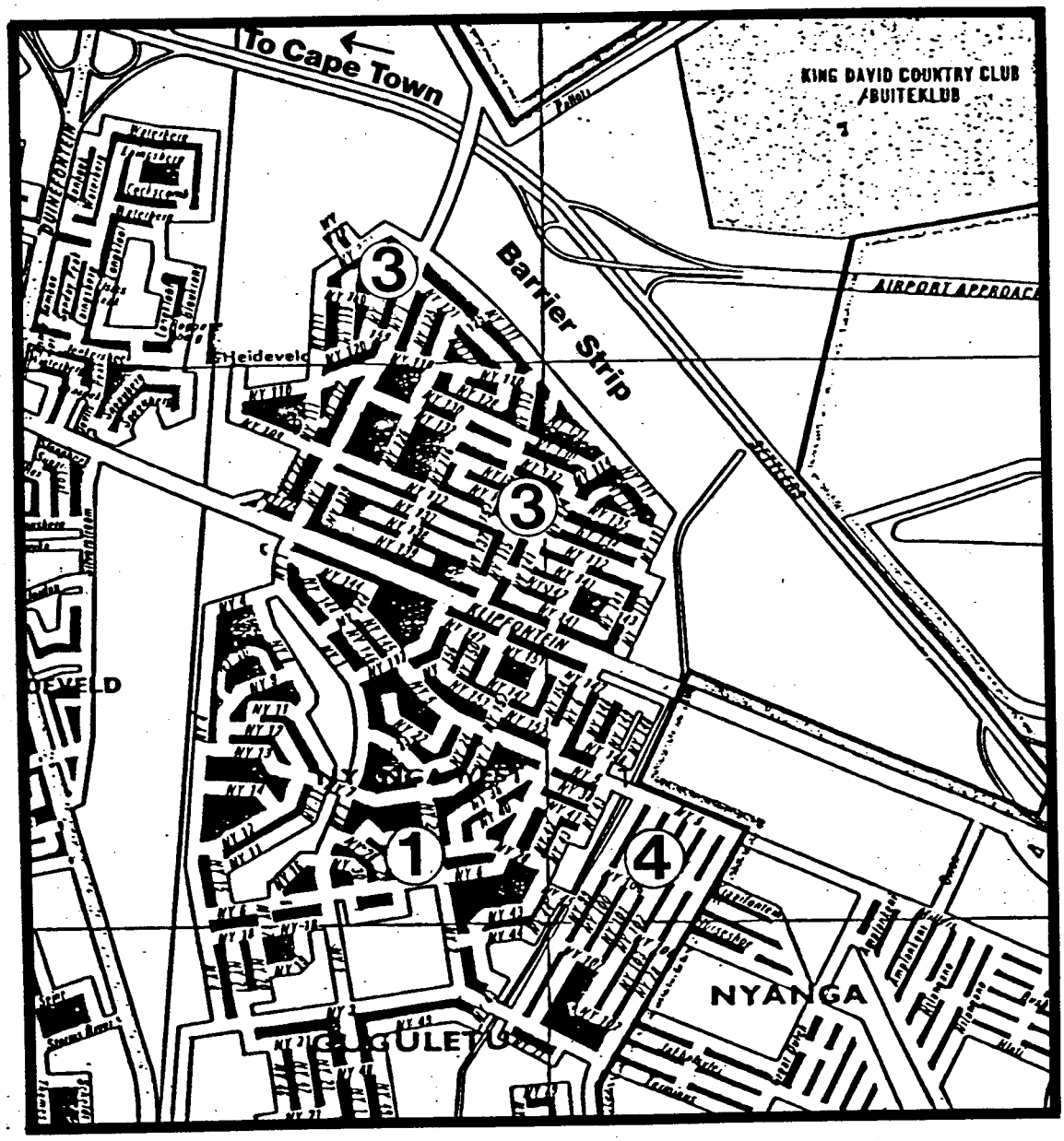
1. I have taken cognisance of the articles by West, 1975 and Hammond Tooke, 1978, in which the terminology of ancestors versus shades is raised. Those who are mentioned by name are regarded as being personally involved in the lives of their descendants. The izinyanya who are not mentioned singly lived so long ago that their descendants are not personally familiar with them, nor do they know them by reputation.

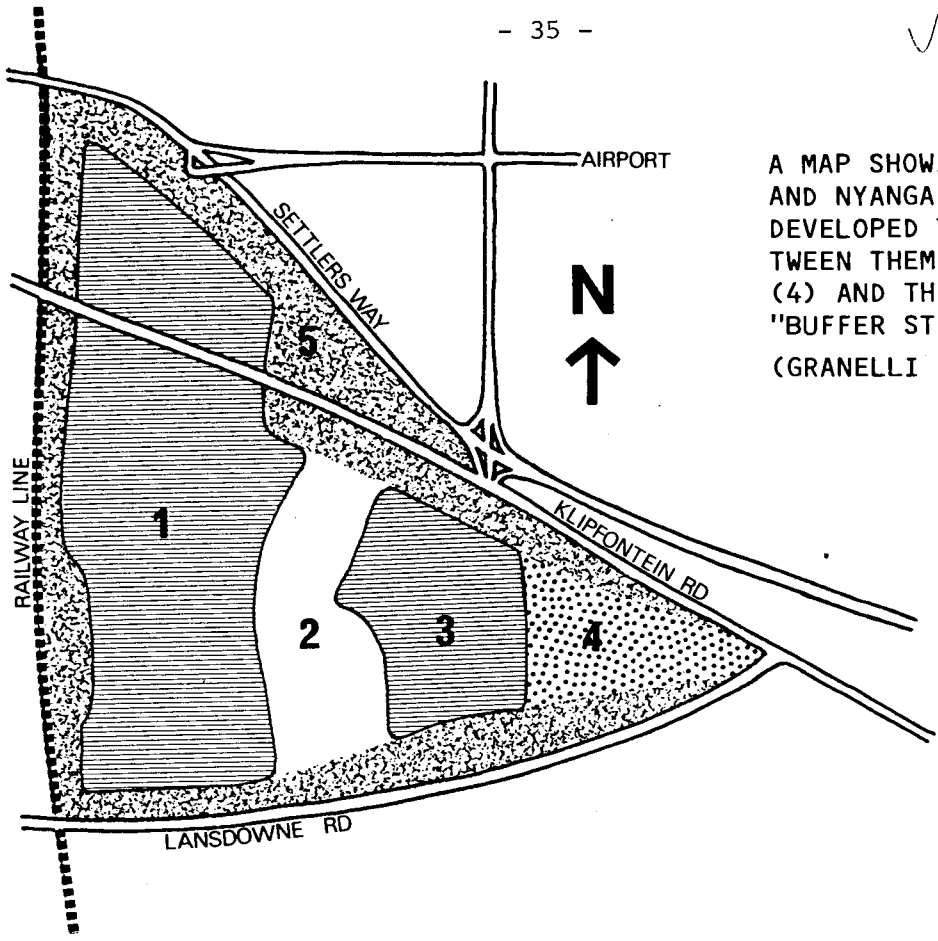
2. Refer to glossary for more detailed definition.

3. Lacanian psychoanalyses and semiotics, to mention a few philosophies, have ben incorporated into Althusserian-type Marxism, because of the level of empty formalism at which they operate. (Clarke, !980 : 189).

GUGULETU SECTION 3

SKETCH MAP INDICATING PATTERN OF STREETS.

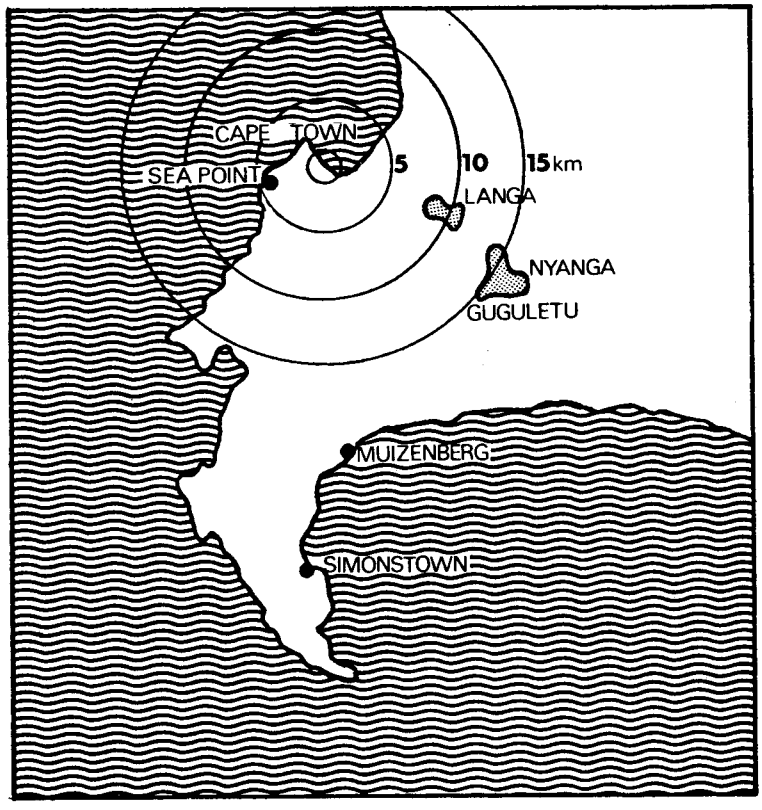




A MAP SHOWING GUGULETU (1) AND NYANGA (3) WITH THE UNDEVELOPED TRACT OF LAND BETWEEN THEM (2) CROSSROADS (4) AND THE SURROUNDING "BUFFER STRIPS" (5).

(GRANELLI AND LEVIATHAN, 1977)

DIAGRAM SHOWING THE DISTANCE OF TOWNSHIPS FROM THE CITY CENTRE.



CHAPTER 3

GUGULETU : THE SETTING FOR THERAPEUTIC MANAGEMENT

The context for therapeutic management provides what Charles Leslie (in Janzen, 1978) called "an establishing shot". The latter entails a broad view of the historical and politico-economic context of Guguletu, before honing in on the lives of the residents for "tracing shots" and "close-ups" of their illness episodes and therapeutic networks.

Towards the end of 1959, building was begun at Nyanga West, an area which was being developed by the Cape Town City Council for the resettlement of families from the slums of Windermere, Retreat and Cape Town (Horrell, 1961). The resettlement of "Blacks" to outlying areas was part of the Cape Town City Councillors' social engineering (Western, 1981) as early as the 1880's. This area is today known as Guguletu, "Our Hope", an ironical name to give to a township with a long history of crushed resistance.

According to Western (1981 : 42), in 1936 a third of all Capetonians lived in mixed zones: however, mixing of residential areas was not tolerated in a completely laissez faire manner and legal enactment of residential segregation for "Black" Africans had started in earnest in South Africa by 1890. By that time there was a population of "Blacks" numbering about 10 000, according to Saunders (1979). Many migrants came from the Eastern Cape and the Transkei to find work and were employed at the docks because "Coloureds" avoided this work.

> "It could be anticipated that if a white power-holding minority were to enact segregative laws for urban areas through the motive of fear for its future security, it would first enact them against those it perceived to be the greatest threat. These would be the Black Africans - the Swart Gevaar - who are not only those who outnumber the whites in the land, ... and whose material standards of living and health have generally been the lowest in South African urban areas."
>
> (Western, 1981 : 45, my emphasis)

According to Saunders (1979), the first suggestions of controlled separation were made by Matabele Thompson, who suggested compounds for the dock workers similar to the ones he had helped to implement in 1899 in Kimberley. This contention was supported by a report made by Cape Town's Medical Officer of

Health, who found the living conditions of Africans in Cape Town "very undesirable socially and health-wise."(1)

By June 1899, these individual complaints were joined by a deputation of Whites from the "mixed" areas of Woodstock, Mowbray, Rondebosch, Claremont and Maitland, who met the Secretary for Agriculture to ask him to establish a separate area for "Blacks". Uitvlugt, out on the Cape Flats, well beyond the precincts of the developed Cape Town area, was considered suitable. By the following month, a Bill was passed in Parliament permitting industrial employers to establish locations for their African employees. James Rose-Innes claimed in Parliament that the town was "overrun with hordes of Natives - uncivilized barbarians."(2)

The Bill was at first set aside as it was considered unfeasible, but by 1899 the Cape Town City Council had begun to negotiate for a site to which they hoped to be able to encourage Africans, if necessary by force. The Maitland plot, originally planned for sewerage disposal works, was selected as it was a large area, well beyond the centre of Cape Town. The inhabitants of Maitland, however, complained about this plan as they too did not wish to live near an "African location."(3)

After discussion it was decided that the government would take the responsibility of running the location and so the government-owned farm, Uitvlugt, was eventually ear-marked as the site. Further progress, however, was halted because in 1901 bubonic plague broke out. The African dock workers were the first victims, as they lived under unhygenic conditions. Following this, slum clearances were begun and isolation hospitals were started at Uitvlugt, well beyond the city centre, under the legitimation of Section 15 of the Public Health Amendment Act of 1897 (Saunders, 1979 : 140).

> "The original slum clearances were ... justified in health terms, but the plague only accelerated a process of discrimination and segregation which had long since been in progress. By moving the "Blacks" out to other equally unhealthy living conditions, the White community benefited and were able to justify the move in humanitarian terms. A myth grew up about the origin of N'dabeni (as the site at Uitvlugt was called) as a liberal attempt to provide healthier living conditions for "Blacks".
>
> (Wilson and Mafeje, 1973 : 3).

Housing at Ndabeni "the place of speaking" was described by Wilkinson (4) as "huts unfit for the accommodation of pigs." Despite resistance to increased rent and transportation costs, rioting and demonstration meetings in 1902, Uitvlugt became a township in less than fifty years: the community was disrupted, however, and the people uprooted. During the war and the following years of economic depression, Ndabeni was gravely neglected. Nevertheless it became "home" to the residents despite the overcrowding (Saunders, 1979 : 167).

By September 1921, it was decided that the Cape Town City Council would have the responsibility for administering a new model location to replace Ndabeni, which would in turn be converted into an industrial area. Langa was the name eventually chosen for the new location. From the outset, the new location was unpopular, one of the reasons being that it was even further out on the Cape Flats. The Ndabeni residents resisted, but despite their efforts, the process was only slightly retarded. In 1923 Langa was established and in the same year, the Natives' (Urban Areas) Act was passed.

Protestations were made, for example, by H.R. Ngcayiya of the South African National Congress who said at a mass meeting that Africans were thought "to be suffering from some contagious disease against which the 'white' race must be protected." (5) These protestations were ignored and in 1922, Smuts made it clear that Africans would not be allowed freehold title in the locations.

The Urban Areas Act although strictly implemented has not been successful in preventing illegal residence. In 1952, according to Wilson and Mafeje (1963), only a third of the "Black" Africans were living in the townships because there was insufficient housing, then as now, to meet the demand. Blacks were needed as cheap and rightless labour but their proletarianization (Bundy, 1970, 1972) was not accommodated realistically: in Langa, for instance:

> "When it was found that tenders exceeded the estimates, it was decided to make the married quarters two-roomed instead of three, to use asbestos and concrete instead of brick for some of the building, and to increase the proposed rentals." (6)

Some of the councillors approved of these changes on the grounds that the facilities at Langa should not attract more Africans to the city (7).

When Ndaben, Langa and, later, Nyanga West, today known as Guguletu, were created the reasons for resistance were very similar, for instance:

1. Increased costs of transportation and consequently higher living costs, for example: when Guguletu was formed, the residents moved from Simon's Town, Retreat and Windermere and suffered a great increase in transportation costs, as they had to commute daily to their work in Simon's Town or in the city.

2. The destruction of a sense of community when re-located to new, stark, townships without any distinguishing characteristics which might enable the residents to call the place home.

According to Senator P.Z.T. van Vuuren in 1977:

> "We make no apologies for the Group Areas Act and for its application. And if 600 000 Indians and Coloureds are affected by the implementation of that Act, we do not apologize for that either. I think the world must simply accept it. The Nationalist Party came to power in 1948 and said it would implement residential segregation in South Africa. And we shall implement that policy. We put that Act on the Statute Book and as a result we have in South Africa, out of the chaos which prevailed when we came into power, created order and established decent, separate, residential areas for our people."
>
> (in Western, 1978 : 85).

The belief that "Black" and "White" cannot live harmoniously alongside, is therefore the true reason for apartheid at the local level, not "the need to provide healthy living conditions", which was the original rationale for the development of townships.

Mrs. A.D., for example, told me how her mother was moved from Ndabeni, where she lived, to Nyanga West and "just dumped there". They had many memories of Ndabeni. Her mother's sister had died during an uprising against the rise in cost of train fares, when she had been jostled off the platform in front of a moving train. Mrs. A.D.'s maternal grandfather had "nursed the Steenbras dam", a job which he found very satisfying. The family did not stay in Nyanga West, where they were relocated. Instead, they went to live in a shack on "Mr. Adriaanse grond", known as Eureka Estate. The family had to pay a cent for every tin of water they fetched from his taps.

> "We went to school with the coloured children at At. Andrew's Church School and we were quite happy there, except that we never had shoes. My mother's sisters had married coloured men and we knew the people there".

Their family was, however, once again forced to move. They went to Windermere, but despite resistance were forced back to Nyanga West once again:

> "We left behind all our things and had to start over again. We were given no houses at first - just the tin for the roof and the walls and some other things. There were not even floors!... Then our family came to this house with brick walls. But it had no doors inside, no electricity, no sink and no ceiling. Not even a stoep!"

It should be emphasized that vignettes are presented in this chapter as qualitative illustrations of the living and working conditions of the "Black population".

Guguletu covers an area of 542,6 ha.: its closest point is approximately 15 kilometres from Cape Town's city centre and the furthest is about 20 kilometres. The township has two entrances: one via Klipfontein Road and the other via Settlers' Way. These can be easily cordoned off during riot situations. Although access to Guguletu can be easily gained by Whites, officially they must have a permit.

Although the township is nominally divided into five sections, it is in fact, only divided into three separate sections. The highly structured grid-divisions also make it possible to cordon off sections, if it is deemed necessary.

Section 1 has quarters for families, but no accommodation for single men, while Section 2 has two types of accommodation for men living singly and Section 3 has only one kind of single men's accommodation. An attempt has been made to separate residents from migrant workers, who often have more grievances and live in poorer conditions.

Dr. Koornhof (in Hansard No. 4, August 1981, Col. 3) quotes the de facto African population of Cape Town as 199 600 and the de jure population as 114 164. Thus 84 000, or approximately 42% of the Black population is classified "illegal". The official estimate of the population of Guguletu alone, in 1978 was 54 069 with a density of 99,7 persons per ha.

As such it is the largest location with the largest population of residents who qualify in terms of Section 10 to live in family residences. In terms of the Blacks (Urban Areas) Consolidation Act (No. 25 of 1945) as ammended:

> 10(1) No Black shall remain more than 72 hours in a prescribed area unless he produces proof in the manner prescribed that
>
> a) he has since birth, resided continuously in such area; or
>
> b) he has worked continuously in such area for one employer for a period of not less than ten years or has lawfully resided continuously in such area for a period of not less than 15 years, and has thereafter continued to reside in such area and is not employed outside such an area and has not during either period or thereafter been sentenced to a fine exceeding R500 or imprisonment for a period exceeding 6 months; or
>
> c) such Black is the wife, the unmarried daughter, or son under the age of 18 years, of any Black mentioned in paragraph (a) or (b) of this subsection and after lawful entry into such prescribed area, ordinarily reside with that Black in such area; or
>
> d) in the case of any other Black, permission so to remain has been granted by an officer appointed to manage a labour bureau... due regard being had to the availability of accommodation in a Black residential area.

Overcrowding in Guguletu is extreme, due to the lack of construction since 1966 as "it has been government intention to progressively reduce the number of Blacks in the area" (Granelli and Levithan, 1977 : 14). In December 1975 there was a backlog of 1 440 housing units, according to the Peninsula Bantu Administration Board (BAAB), under whose jurisdiction the three townships, Guguletu, Nyanga and Langa, now fall. The recent unofficial estimate made by the South African Institute of Race Relations is that 80 000 Blacks are living in Guguletu and Nyanga East alone. The actual overcrowding is extreme as there are only 7 376 houses excluding migrant hostels. This has a directly detrimental affect on living standards (see Chapter 4).

At this point, it is necessary to argue that it is unrealistic to try to separate the urban township population of Guguletu into supposedly different ethnic groups, because of the extent to which they share a common way of life. At most, one can say that 96% of the Black population of Cape Town are of Xhosa-speaking origin (Granelli and Levithan, 1977). Initially the

Amaxhosa came from the Cape frontier regions where the Ciskei and Transkeian "homelands" are today established. After a century of battles and the destruction of their economic order, they were left with only their labour power between themselves and poverty. This they sold in the urban areas, Cape Town being one of the important centres.

According to Lye and Murray, how one identifies the population to be studied in South Africa depends on the nature of one's interest:

> "The boundaries of language, culture, economy and state do not coincide... it is by no means evident that the most significant boundaries within the population of the subcontinent are ethnic boundaries".
>
> (1980 : 9).

For the purpose of this thesis, the population will simply be regarded as a more or less homogeneous grouping, who in some situations may mobilize ethnicity (Epstein, 1978; Mitchell, 1960, 1966), for particular purposes. The establishment of coping networks, of which the amagqira are but one alternative, is not, however, based on any particular ethnic identity, although African identity is important.

Since 1973 the Peninsula Bantu Administration Board has been in control. It is a separate, legal entity, self-financing and empowered to raise loans (see p.47 for a breakdown of finances). Although long leasehold has been introduced in other areas of the Republic, the Cape Peninsula BAAB until 1982 only provided monthly leasehold. People appear to be sceptical about the benefits of 99 year leasehold; and the required R400 deposit is regarded as "risky". The construction of family dwellings has, with only very recent exception, been undertaken solely by the local authorities. During the last ten years, the only houses built were in Guguletu, where 36 868 units were erected. Between 1966 and 1972, no new houses were built for residents (Horrell, 1972) except by private employers for migrant workers and they had first to apply to BAAB, who administers all housing.

> "With the exception of a small population of detached and semi-detached houses, all of the dwelling units are built in terraced rows of up to eight units in length. This is particularly noticeable in Guguletu where the type of N.E.51/6 terraced three-roomed units comprises over 80% of the habitable rooms in the Peninsula".
>
> (Granelli and Levithan, 1977 : 16).

STATISTICS

Dormitories erected since 1972

In Section 2

Type of Accommodation	No. of Beds
Board Hostels	2 752
Employers' dormitories	872
Total number of single men	3 624
Total population	22 148

In Section 3

Type of Accommodation	No. of Beds
Employers' dormitories	846
Family Units	350
Total number of single men	1 196
Total population	16 320

(UPRU General Statistics, 1978)

It is generally recognized that migrants live under poor conditions. Many migrants move to squatter camps or live in shacks behind family houses, in order to bring their wives and families to Cape Town (Granelli, 1977 : 55). Many "illegals" live in these shacks, which are also essential for the families who do qualify to live in family houses, because of their small size and the housing backlog. By 1977 a 2 000 unit backlog existed (Smith and Digby, 1978).

In a house-to-house survey of 3-roomed standard family houses, BAAB estimated an average of 6,52 persons per family, therefore 2,48 persons per room in 1975. This is a gross under-estimate. Cape Town University's Urban Problem Research Unit, however, estimated 8 persons per household on average, not including unofficial lodgers. The latter estimate is more realistic as bourne out in the survey conducted for this project. (See Chapter 6 for further discussion). The large number of unofficial lodgers in shacks makes the pressure on the facilities of one house much greater than has been estimated by government research.

Such over-crowing is an anathema to the residents. According to an elderly man, T.M.:

> "We have to sleep on the floor of the kitchen, people who are sick have to sleep in the sitting-room. How can we not be affected by sickness when we live like this?"

According to P.M., a matric student:

> "Germs spread here because BAAB doesn't provide enough houses. They don't clean up in the streets, either. We are so squashed together in one house that if one person gets sick, we all do."

Mrs. A.D. claims that she wants "her own home", because:

> "I don't go to the country, I am going to die here in Guguletu."

When she and her family were moved from their temporary shacks they lost all their housing materials. Over the years they have had to spend a great deal more money. When they moved into their rented house they had to put in all the fittings themselves.

"There was just sand right outside the front door. Ticks and lice get into the children's hair so Leonie must shave it off. There is no grass, nothing here. Everything costs money, I cannot do my bedroom yet - I can't sleep there, there is no ceiling and the roof does not keep the cold out. First the rent was R8,50, then it was R18,10 and now they (BAAB) are going to put it up to R22... The front rooms of the house were too small, I felt closed in and there was no room for iinthlombe. We knocked the dividing wall down to make a nice big room. But I know I am going to get into trouble, (8) even though it costs money and it looks better; another thing - we have no bathroom inside. The one outside has a door too small, so that the draught makes us cold in winter."

Householders also claimed that it was not worth putting one's name down at the Uluntu centre for 99 year leasehold, because they believe that the children might lose it in the end. An informant explained:

"We know nothing really belongs to us here",

a complaint shared by many other people living in Guguletu who resent that they are not allowed to own property in the urban area.

Some of the shack-dwellers in the backyards are exploited by tenants, for example: an elderly woman at Guguletu clinic explained that she worked for the people with whom she stayed in lieu of rent. At the time of meeting, she was bringing their son with a broken arm to the clinic and also fetching "pills for her head". She informed me she was being sent the following week for tests. She was very anxious and burst into tears, saying:

"I have no house, no family here and I am getting old, who will care for me?"

Without legal status, in terms of Section 10, jobs are scarce and her life is fraught with anxiety. She leaves her belongings in one shack and moves from family to family doing work for them. Two of Mrs. A.D.'s amakwhetha, 'Suselina' and 'Esther', for example, are in a similar state of anxiety because they too are without legal status.

According to Graaff and Murray's (1977) random sample of 211 migrants, of all those with dependants in the Ciskeian and Transkeian homelands, 40% owned no land and more than 50% owned no livestock. These dependants therefore rely almost entirely upon the remittances sent to them.

Lack of employment for both legals and illegals is a constant complaint in the Coloured Preference Area of Cape Town (9). In 1954 it was decided

that workers classified as Coloured were to be given preference in the Western Cape, and that in this way the influx of a Black population would be controlled. In January 1955, Dr. W.M.M. Eiselen demarcated an area of the Cape Province, west of certain points (today known as the Eiselen Line) which would become a "Coloured Labour Preference Area" in which the numbers of Blacks would be limited.

Many informants told me that they had been looking in vain for jobs, including young matriculants, for example:

Two girls of 19 years of age said that they had been looking for jobs in factories for a year. They had been turned away because of lack of experience and because "employers only wanted Coloureds".

> "They listen to your voice on the phone; if you sound like a Black then they say 'Sorry, we have no work for you'. I am not going to work as a domestic servant: I have a matric, but there are no jobs."

There also appears to be little job security: for example, in one family the father, son and the niece's husband, who came with his wife to look for work legally in Cape Town were all turned away during August from Koeberg, as they were no longer needed for construction purposes. The family is now in financial need as they were the main breadwinners.

Another example was given by a young woman of 24, "Ek het al lankal vir Irvin and Johnson's gewerk en toe kap hulle baie meisies af.... Nou sit ek." (I've worked for a long time at Irving and Johnsons and then they got rid of many of the girls... Now I am without work).

Contract workers suffer greatly because when under contract, they have no flexibility of movement, even in times of perceived crisis, for example: Dr. P. at Valkenberg Hospital treated a migrant worker who desperately wanted to return to the Ciskei on his father's death and spoke to his shades all day whilst he gardened on the Prime Minister's estate. Dr. P. fortunately understood that he was not, in fact, mentally disturbed as suspected, but merely very anxious to fulfil his duty to his father. He gave him a train ticket to the Ciskei.

Other migrants, for example, attend Mr. C.G. for advice, based on fortune-telling (vumisa), concerning affairs at home over which they have no control.

Mr. C.G. also "makes up" medicine for luck with employers and for belongings stolen from hostels where there is little privacy.

A client at "Soekie's shebeen" said "Our problem is drinking, but what are we to do? This our way to get happy".

Every section has a liquor outlet built by BAAB, but the shebeens where comparatively nutritious utywala is brewed are illegal. (10)

> "Describing the situation in Black townships, Mr. Hoho explained the need for shebeens. He said that there were no proper facilities for entertainment in the townships and taverns filled this gap.... besides liquor outlets would provide work for many unemployed "Black" youths and money would provide food... This would draw new wealth into Black urban areas which could to some extent be used for education and sports training - in this way, we could keep the money here in Guguletu."
>
> (Cape Times, 26.2.1982).

Mrs. A.D.'s eldest son, G, works at one of the liquor outlets, but since he started to work there he has become a heavy drinker. Other members of Mrs. A.D.'s network, for example, her umkwhetha, "Nobulawo's daughter, has a husband who also works for a liquor outlet and has a severe drinking problem. The examples of drinking problems were numerous amongst Mrs. A.D.'s fellow amagqira and novices, for which they were seeking help as the symptoms of over-drinking can be considered indicative of a sign from their ancestors that they should become diviner's initiates.

According to Dr. Francis Wilson (1972), in 1962 a referendum was held to establish the popularity of the introduction of beerhalls and bottle-stores into the location and 79% of voters, including migrants in the hostels, stated that they were opposed to the introduction of the outlets.

The liquor outlets were severely damaged during the riots and BAAB's chief source of finance has been threatened. Apart from liquor, rentals constitute BAAB's major source of income. The sources of income are as follows: (11)

Liquor	59,9%
Rent	17,8
Labour Bureau fees	9,0
Bantu beer	5,9
Interest on Levy Fund	2,7
Fines	2,1
Other	2,6

"Rentals are uniform irrespective of the age or condition of the houses".

(SALDRU, W.P. No. 35, 1981 : 21).

In June 1978 (UPRU general statistics paper), the estimated expenditure on transport as a proportion of income was as follows:

Langa	3,3%	5,5%
Nyanga	4,4	6,2
Guguletu	4.1	8,8

Guguletu residents claimed they had to pay approximately 74 c. for a return ticket to Cape Town city centre. The rise in the transportation costs severely affects the viability of some "charing" jobs, for example, a woman who works in Sea Point claimed:

"If they pay you R5 a morning or so, and you have to pay for bus fare and your own lunch, it isn't worth it any more."

Not only is the cost of transport high, but the distances which workers have to travel necessitates less sleep and leisure time.

"My husband works at Simon's Town and has to wake up about 4.30 a.m. because he must also walk to the station and catch a train at 5.30. He gets home at night at 7 o'clock. He has just had his tonsils out at Groote Schuur and he gets very tired."

When ill, the problems of getting to hospital are legion, particularly if one does not own a telephone.

Susan who had been in hospital for a ruptured ulcer and had to return to Conradie Hospital for X-rays, was unable to get to hospital as her severely arthritic legs prevented her from walking to the bus stop. Another elderly woman, who had had a heart attack had to wait an hour for an ambulance from Groote Schuur Hospital.

Guguletu has one Day Hospital and one polyclinic which serves both Guguletu and Nyanga. Municipal doctors attend the clinic for eleven sessions per week and the Day Hospital has five full-time doctors and twenty-three nurses. One social worker serves Langa, Nyanga and Crossroads (Hansard, 11 June, 1982). At the Guguletu clinic there are sections for TB (12) and VD (13) as well as a maternity section. For deliveries, however, mothers have to go to "Heideveld" because there are no facilities in Guguletu.

Guguletu Day Hospital is "unpopular" because of the quality of the treatment and the inadequate number of doctors. Without exception, mothers claimed that they would always prefer to take their babies to the Red Cross Chidlren's Hospital because of the good treatment they received. Only the extra distance and resultant cost of bus fare prevented them from doing so.

The proverty disease, Tuberculosis, appears to be a serious problem in Guguletu; in a survey involving 20 households, 10 cases of TB were reported. According to Professor Glatthar, (14):

> "TB is South Africa's most serious health hazard. At least 10 victims die every day. Studies show there are 120 000 active cases in the country at present, but 80 000 are undetected... There are an estimated 10 million dormant cases... these form a pool of infection that can erupt if they are malnourished, inadequately housed or under stress."

According to Professor Benatar (15), TB accounts for 83% of all notifiable infectious diseases reported in South Africa. It occurs in 20 per 100 000 Whites, and 300 or more per 100 000 among "Blacks" (S.A. Official Year Book, 1982).

Mrs. A.D.'s husband, for example, has suffered two tuberculosis illness-episodes. He first went down with it in 1964 and was treated at Westlake Hospital, seven years later it recurred. According to his wife, it occurred when they, as a family, did not earn very much because the eldest children were not old enough to work and their schooling and maintenance costs were at their highest. Mrs. A.D.'s sister, E, also had TB at this time. Three doors down from Mrs. A.D. lives a woman who lost both her husband and her eldest daughter within the same year. By the time they recognized the symptoms it was too late.

As far as schooling facilities in Guguletu are concerned, there are 15 pre-schools which cater for 1 200 children. An estimated 27 000 pre-school children exist in the area. In 1982 another créche opened in the Ulunti centre which caters for 80 children. Other schooling facilities are as follows:

	Black pupil-class ratio	White pupil-class ratio
9 Lower primary	65 : 1	
6 Higher primary	60 : 1	30 : 1
2 High schools	43 : 1	

(UPRU statistics, 1978).

In 1980, on the twentieth anniversary of Sharpeville and the fourth anniversary of the Soweto riots of 1976, rioting once again broke out throughout the Republic, but social unrest was most prevalent in the townships of Cape Town. Schoolchildren filled with a new spirit of confidence asserted their grievances through their only available channel, violence. According to Professor R.E. van der Ross, rector of the University of the Western Cape:

> "The action taken by students and pupils in the unrest is the outflow of a long process of exclusion... this is why they have recourse to these means."

Re-registration in August 1982, as far as the high schools in Guguletu are concerned, is 60% lower than in 1979 before the boycotts began: (16)

> "Pupils have reported unease about the application form which every child has to fill in. The form states that pupils will subject themselves to disciplinary action 'should it be deemed necessary by the authorities concerned'.. Things at our schools are still bad and what they are asking us to do is to just keep quiet about our grievances."

Another source of discontent is the imposition of age limits for 1982, on older students who wish to remain at school and might be a source of trouble. This is particularly hard as many students have to work for a while to help the family finances. Others only start school at the age of about 7 or 8 years of age (17).

The Cape Flats has one of the highest crime rates in the world, according to M. Slabbert and D. Pinnock, a criminologist and a sociologist respectively, both at the University of Cape Town (18). According to these writers, a contributory factor is the effect of relocating families in terms of the Group Areas Act. In a study of these effects, Mr. Pinnock ascertained that both communities and families were disrupted. Houses provided by the local authorities were too small for extended families to live comfortably together. In the process of relocation people are rehoused amid strangers and consequently social order begins to crumble. Transport, bread, electricity and most other costs have risen recently, lowering standards of living to the extent that it becomes imperative for mothers to seek employment.

With neither mothers nor relatives to supervise them, with no amenities and

little inducement from schools, whole generations run wild on the street. Many join gangs which are, in many instances, violent. The result is that on the Cape Flats there is 1 murder every 12 hours, a robbery every 90 minutes, a rape reported every 7 hours (although most rape cases are unreported), an assault every 30 minutes, property damaged every 80 minutes and a theft reported every 22 minutes.

There has been a serious increase in the crime rate in the last four years. If one compares statistics from 1978 with 1982 this is glaringly apparent.

	1978	1982	1978	1982
	Guguletu & Nyanga		Langa	
Murder	55	133	36	53
Rape	112	138	18	32
Culpable homicide	1	-	-	-
Assault	135	2612	563	730
Robbery	332	471	88	132

(19)

According to M. Slabbert, juvenile crime in particular is on the increase. She found in a recent survey:

> "There is little to do in townships. Gangs have become functional. Youths are alienated, often hungry and frustrated."
> (20)

According to UPRU's 1978 statistics (updated), the following facilities exist: 3 community centres; 2 swimming baths, 2 tennis courts, 2 enclosed fields, one open soccer field. When one considers that the de facto population of Guguletu is much larger than estimated, the sporting facilities are abysmally inadequate.

> "Poor sports facilities in Langa, Guguletu and Nyanga are holding back sporting standards, according to sports administration. Players could only train after work which left little time before dark, and no pitches were floodlit..." (21)

Representatives of the Western Province rugby and football boards said that the fields in Guguletu and Nyanga were in even worse conditions than those at Langa. A spokesman for the soccer board said the Guguletu field was

uneven, covered with gravel and had patches of soft sand; there were no seats, changing facilities, etc. Few people watch the sport because of the lack of amenities.

At present no co-ordinating system of civic representation exists. The Bantu Advisory Board constitutes the only recognized official mouthpiece. It is regarded by residents as a charade. In times of crisis, for example, over resistance to Dr. Koornhof's Orderly Movement Bill, there is no powerful civic body through which grievances can be voiced. In this way an attempt is made to silence the public opinion of urban dwellers.

From the above discussion, it can be seen that the central sample of 21 households is drawn from a working class population who by virtue of South African classificatory laws, are in a structured position of poverty and powerlessness. One can also see that as a result of their impoverished circumstances, their experience of physical labour to an old age, a low pension and generally poor living standards, that it has a detrimental effect on their health standards. One deduces that in stressful circumstances of this nature, social and not merely biomedical healing is essential.

According to Philip Mayer (1980 : 3), who was writing specifically about migrants, but whose contention concerning their resilience and coping abilities can be applied equally to all the people living in Guguletu:

> "We are not trying to divert attention from the inhumanity of the system but on the contrary to illuminate it through the contrast with the humanity of the people."

This thesis focuses especially on the coping networks of people in need of social healing.

FOOTNOTES

1. Stanford Commission, 119, Cape Times, 27 December 1899.

2. Cape Times, 27 July 1899.

3. ibid.

4. Wilkinson argued on behalf of the residents of Ndabeni that as they had been forced to move involuntarily, they were not legally bound to pay out on transportation costs (Saunders, 1979 : 177 from Cape Argus, 6 July 1902.

5. Saunders, 1979 : 177, from Cape Times, 7 June 1922.

6. Saunders, 1979 : 176, from Cape Times, 10 October 1925.

7. Saunders, 1979 : 176, from Cape Times, 7 May 1924.

8. It is necessary to apply to BAAB for permission to make alterations as they do not own the property and have only leasehold rights.

9. According to Dr. Koornof (Cape Argus, 23 April 1982).

10. According to the Government Gazette, No. 5108 of May 1976: A trader may sell various types of goods within his establishment, provided he has a licence. Licences are limited to government approval and there are difficulties in obtaining any financial aid, no matter what the nature of the business. In 1975 there were only 184 licences granted to "Black" traders (Smith and Digby, 1978 : 101).

11. It is common knowledge that the Peninsula BAAB is extremely short of finance. "According to the Annual Report of the Department of Bantu Administration and Development for the year April 1976 to March 1977, a number of Bantu Administration Boards were hard hit financially by damage caused by the unrest in urban black areas. The Board's sources of revenue were adversely affected and their liquidity further weakened in that insurance cover was almost immediately suspended, and that damage amounting to several million rand is still the subject of uncompleted negotiations with insurance companies (Cape Times, 29 March 1978).

12. The Vice-Chancellor of the University of Cape Town, Dr. S.J. Saunders, said: "The medical profession should aim at eliminating the root causes of socio-economic illnesses such as TB and malnutrition, rather than treating each case." (Daily Express, 14 February 1982).

    The problem with this analysis is that he too is locating the problem within the medical profession, as opposed to within the politico-econimic structure of South Africa, i.e. within Medical systems as opposed to Health systems.

13. According to the view of Mr. Ron Ballard, Chief Scientific Officer of the Department of Microbiology at the School of Pathology of the University of the Witwatersrand and the South African Institute for Medical Research:

> "The policy for separate development and its ramifications - migrant labour and the lack of recreational facilities for urban Blacks are the major factors in the spread of Veneral Disease in South Africa."

Mr. Ballard went on to say that the factors listed in any standard text as responsible in sexually transmitted disease make it clear the present socio-economic conditions in South Africa allow the diseases to thrive.

> "While it's true that there is a high incidence of these diseases in other parts of Africa, local legislation - such as influx control - affects the incidence adversely."

14. Daily Express, 14 February 1982.

15. Cape Times, 4 August 1982.

16. Cape Argus, 2 June 1980.

17. Cape Argus, 2 June 1980.

18. Cape Herald, 3 April 1982.

19. Hansard Reports for the years 1978 and 1982.

20. Cape Herald, 3 April 1982.

21. Cape Times, 28 June 1982.

CHAPTER 4

THE POPULAR ARENA : THE BROAD THERAPEUTIC CONTEXT IN WHICH AMAGQIRA NETWORKS ARE SITUATED

> "... classification and causality (are)... important aspects of thought in African medicine and health... particularly in those settings where multiple paradigms of diagnoses of treatment are found. Although there has been voluminous work, usually in community studies, on the relationship of disease and healing to spirit possession and mediumship, on the social dynamics of witchcraft and witchcraft eradication movements, and on the magic and ritual in curing ceremonies, there is a need now to better comprehend within a single general mode, the inter-relations among the several types of disease-theories, and between them and notions of modern medicine, or to account for diseases and conditions deemed appropriate for biomedical practitioners. Further, there is a need to show how biomedical paradigms have themselves been assimilated to African thought, and now exist alongside of, synthesized with, other modes of thought and practice."
>
> (Janzen, 1981 : 169, emphasis added)

It is this above-mentioned problem, succinctly outlined by Janzen on which I focus my attention in this chapter. A range of illness-episodes suffered by residents and migrants within the "popular arena" will be contextualized, as will the relation between natural and non-natural explanatory models, in order to ascertain the degree of overlap and connection amongst therapeutic options. By providing the context of and rationale for therapeutic choice, one is able to see that amagqira networks are not entirely separable from other therapeutic networks, such as those associated with African independent churches, other indigenous healers and biomedical practitioners.

The question of what constitutes a natural or a non-natural diagnosis cannot be answered philosophically in the way Fortes attempted because this approach denies the possibility of a definition:

> "As one listens to the discussions about natural and non-natural causation, one slides between these different senses which belong to the history of the concept and its changing name..."
>
> (Janzen, 1981 : 429-30).

Steve Feierman (in Janzen, 1981) also attempts a decontextualized analysis of Janzen's (1978) distinctions between illnesses of God (natural) and illnesses of man (non-natural), by proposing that natural illness should not be over-generalized. His argument, however, is critical as it provides no constructive directions, as do the arguments of Comaroff and Ranger (1981), to be discussed below, who suggest the need to analyse therapeutic decisions and explanatory models in a social and temporal context, rather than within an ideological vacuum. In other words, it is suggested that the context of illness is essential to an understanding of the interpretation of non-natural illness aetiology. It is their theoretical approach which has shaped the direction of this chapter.

The ethnographic data presented below support the contention of Frankfurt and Leeson (in Loudon, 1976), Comaroff (1978) and Janzen (1981), for example, that socio-cultural pluralism and openness to a wide range of choices is not purely a modern phenomenon, as Horton (1975) suggested. In the past, the indigenous healing range also provided a wide range of choices between grades of diviners and herbalists; the biomedical options are merely added, thus extending an already existing spectrum. For this reason Horton's references to traditional African Knowledge can be criticized, because it is no longer applicable to selectively interrelated medical paradigms. Mudimbe and Comaroff made some useful cautioning comments on this score:

> "We need to keep in mind the distinction between observers, and actors models...when we talk about pluralism, we have to be sure whether in fact we're talking about a field which appears to be subdivided from the outside, but is really related from within as one repertoire, in which individualists play the field."
>
> (Janzen, 1981 : 434)

It will be argued that there is one therapeutic repertoire at the popular level and that so-called natural and non-natural causation are rarely confused, although they are not regarded as being distinct, mutually exclusive or impossible to re-interpret. They are dimensions which may or may not be highlighted depending on the social context of the episodes. The spacial extent of options was determined, as the distance one has to travel is not an unimportant consideration for patient-family therapeutic management, nor is the time factor. Illness, like all other social phenomena, takes place in a time-sequence and it is therefore necessary to

see therapeutic decisions in the context of the stages and progression of illness. It is also not possible to understand natural and non-natural illness aetiology, except within a temporal context, because diagnoses may be revised during the course of an illness-episode and under changing social circumstances.

Before focusing on disease and therapeutic management within the popular arena, it must be stressed that not all activities are related to the restoration of health: many are prophylactic and relate to the prevention of illness. Bibeau and Comaroff (1981) for example, have disagreed as to whether disease or health should be the focus of analysis. For a full understanding, neither can be ignored, most specifically because prophylactic measures are closely tied to customs associated with rites de passage, the neglect of which causes the ancestoral shades to turn their backs. Through neglecting to follow the wishes of their shades, further misfortune is incurred.

By examining Data Chart I, we are able to establish the range of symptoms suffered by householders in the survey and their explanatory models of illness. Data Chart II indicates their therapeutic actions, both preventative and curative, based on their explanatory models, while Data Chart III gives the time-period of the onset of each illness-episode over the past week, month, year and previous years. This information is tabulated but not converted into statistics as the survey is too small to be necessarily statistically representative. (See Appendices).

At this stage it should be emphasized that households will not be used as the sole unit of investigation, because health standards are largely shaped by external factors. Research does suggest, however, that the considerable economic differences between households, due to the stage of demographic development of the family-cycle, affect the family's overall standard of health; especially with regard to the poverty-disease tuberculosis. I am not, therefore, adopting a strictly Chayanovian (1966) approach to the developmental cycle of families, or only trying to ascertain a dependency ratio which fluctuates over a time period. Nor shall it be argued that economic well-being and health standards are tied to the domestic cycle (Harrison, 1975) although they are strongly affected by it. This would be tantamount to laying the blame of a poverty-disease at the door of the

individual family and denying that health standards are structurally influenced. What I am stressing, however, is that it is useful to see how health standards are affected both at the macro-structural level and at the micro-level of family, extended family and relevant others within a household. Households sometimes correspond with houses or houses and back-yard shacks or across separate houses belonging to members of one extended family.

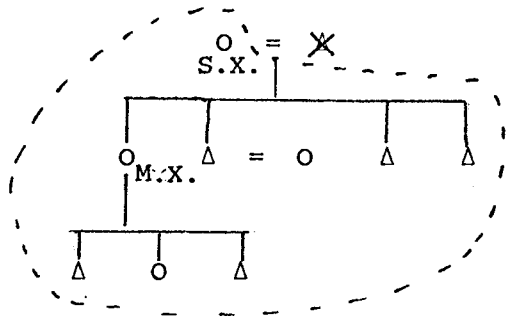
The following households show examples of illness-episodes where only one therapeutic option is used, either sequentially or concurrently. It should be emphasized at the outset that household-membership may or may not correspond with blood or marriage ties, depending on the social context in which relationships are interpreted. The following episodes will be analysed within the context of each household, for the reasons stated above, in order to establish the rationale for therapeutic decisions and management. The households where a wide range of options were employed will be similarly analysed. In this way the context for an understanding of intwaso, set within a range of other illness-episodes will be sketched out.

In the following examples I shall include the following dimensions, not necessarily in this order:

responsibility for therapeutic management;
notion of aetiology;
reasons for treatment choice;
expectations with regard to treatment;
degree of satisfactions with treatment.

Case I: household 2 is presented at the outset for several reasons. It illustrates a specific incidence of severe assault and how some of the family members dealt with the incident, either by positive therapeutic management or by contriving to ignore the problem. The incident highlights the relevence of context for understanding the more complex illness-episodes which follow. It thus demonstrates clearly how the social variables influence the course of an illness-episode.

Case I: Diagram of household members



Key

O = female
Δ = male
| = descent
— = sibling relationship
= = affinal relationship
⌣ = extra-marital alliance
.. = household membership
X = death of a family member and/or household member
▲/● = lodger

S.X.,aged 55, was born in Cape Town. Because of her limited schooling, she was employed as "a char". Four months prior to the inverview, she was brutally assaulted. A bystander called for an ambulance which rushed her to Groote Schuur Hospital, a distance of about 15 kilometers. Approximately an hour after the incident she was hospitalized. She lay unconscious for two weeks and after gaining consciousness was unable to speak. Two months later she returned home, where at the time of the interview she was being cared for by her daughter.

The eldest daughter, M.X.,aged 24, although concerned about her mother, is unable to support her financially, as she has been unemployed since her retrenchment from a food factory. Both S.'s 28 year old son and daughter-in-law are heavy drinkers so that although her son is employed as a cleaner in an old-age home in Sea Point, he contributes little maintenance to other family members. His wife, however, who is employed at a factory in Epping, pays the rent. The other sons of 5 and 8 respectively, are gang-members and without employment. Originally they had intended to work but "gave-up" after unsuccessful searching. M.X. relies on the maintenance money she receives occasionally from her children's father. When he neglects her, the children go hungry. S.X.'s husband died three years prior to the interview. Since that time she has become entirely reliant upon her eldest daughter to intercede with her son and daughter-in-lay for financial assistance,

as they are often violent or disorientated from drinking heavily. In such a household the mother's accident is a severe blow to MX, her three children, all of whom are under five years of age and her two brothers. They miss her for both economic reasons and because she exerted a controlling influence on the family. As far as MX is concerned, the assault occured because of the gang organizations in Guguletu which many young men like her brothers join, because of lack of employment and poverty. It was simply accepted as a misfortune which occurs "every day in Guguletu".

MX was initially not involved in therapeutic management as it was a stranger at the scene of the assault who called an ambulance. She visited her mother in hospital only occasionally because of the cost of bus-fare and because she had no-one to look after the children.

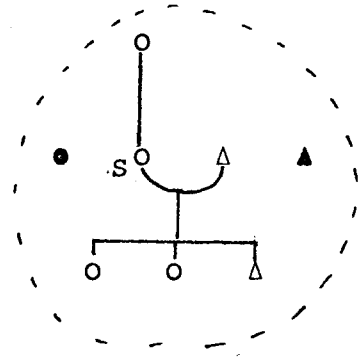
At the time of the interview, MX was dealing with her own anxiety and sense of misfortune by attending Zionist healing ceremonies where she prayed for purification and healing within her family. She has also tried to make her brother and his wife stop drinking, without success, as they reacted aggressively. MX believed that only faith could help them; the alcohol problem was seldom broached and the assault was talked of fatalistically.

This example is useful in that it illustrates in what way a family is economically affected when a responsible bread-winner and head of the household is incapacitated. In this matrifocal household MX is in charge of all home-care for her mother, and prophylactic measures for her children's welfare. (This will be discussed below). Both her brother and sister-in-law are either incapable or unwilling, respectively of motivating any therapeutic action. Their problems were merely compounded in a bid to forget, by drinking. The family's income earned by the elder brother and sister-in-law, was not regularly shared with dependants. This meant that whatever money they did receive was spent on their immediate needs, such as food and clothing. It is also clear from this example that MX sought to cope with the social effects of her mother's injury as opposed to seeking further biomedical aid. This was partly because she considered that there was nothing more that could be done to reverse the physical damage. Secondly, she chose a Zionist Church as opposed to a diviner school because she considered that the Zionists were a more appropriate option for her spiritual needs. She also claimed that had she wished to consult a diviner

or some other indigenous healer (as she has done in the past), she would have been unable to afford the cost of treatment. In general, it can be said that a household's economic situation will be seen to closely determine, not only opportunity for obtaining costly therapy, but also ability to support members who are unproductive due to illness or injury.

Case 2 : household 7 is representative of the extent to which family members are reliant upon disability grants or pensions accruing to one member of the household, in order to balance the "family's budget". This was also the case in Mrs. A.D.'s household (See Case 9: household 20). Despite the fact that Mrs. A.D.'s mother was 78 and terminally ill, she made a two day trip four times a year to East London, in order to collect her pension, as she was not classified as a resident of Cape Town. Although the bus trip cost R60 and she received only R80 in pension money, the trip was considered necessary, because R20 was relied upon "to stretch" the family finances. A similar state of reliance is brought out in the following matrifocal household, the members of which try to cope with but in fact exacerbate their problems by drinking in much the same way as in Case 1 : household 2.

Case 2 : household 7



Soekie (S), aged 35, has always relied heavily on her mother's disability grant, which the mother has received for the last theiry years since high blood pressure and old age made it impossible for her to work. Soekie is very concerned how she, her boyfriend and her children will cope when her very aged mother dies and they lose the grant. Other members of the household include a male lodger, distantly related, who is living illegally in Cape Town and trying to find employment; a female ledger, aged about 60, who along with the other household members, helps S to brew utywala (beer) for their shebeen. This activity supplements their income from the disability

grant. No one in the house has passed beyond Standard I. In households such as this, finding employment is exacerbated by illiteracy.

Soekie complained of having had severe backache and a breast infection within the past year, while the children had suffered from colds. The infection, she claimed "just happened" and was caused by "germs". Her backache, on the other hand, was believed to be caused by carrying the children while she worked. Her initial explanation for her despondency and lack of well-being emphasized somatic symptoms. She also explained, however, that to relieve her tiredness she drank excessively. Heavy drinking was apparent at the time of the interview. At 10 o'clock on a Saturday morning, Soekie and her customers were on the verge of inebriation. She explained her problems as follows:

> "This is a disability house... we have no money and are suffering..."

Soekie extended her own analysis of their "house worries" with the help of her clients who argued with her and included some of their own opinions:

> "We suffer because we are poor and black and so we drink..."
>
> "Also BAAB never comes here to clean up... we have germs here because we are packed together..."

An elderly man took up the argument, saying:

> "You find even sick people here sleep in the lounge and in the kitchen on the floor... even in winter."

Soekie claimed that she did not bother to treat the breast infection herself, although she was trying at the time to rest her back. She eventually went to Guguletu Day Hospital for treatment of the infection which was not healing. Her initial choice was not the Day Hospital, because in her opinion: "The nurses are very wrong... they do not care... they give you aspirins for everything!" They apparently also gave her aspirins for the infection, although she admitted after further discussion that she was also given an effective injection. The fact that the treatment had been beneficial seemed less important than the fact that the nurses were rude to her. At the time she was unable to afford the nearby doctor in private practice who charges R8 per consultation. In her opinion, the problem is that the nurses are rich and educated and they look down upon other Blacks who are

poor and ignorant. She was also annoyed at having to wait half a day to see a doctor. Soekie, like other mothers in the survey, is responsible for therapeutic decision-making. Her mother's disability grant and her own income from the shebeen help to pay for the costs of treatment, as her boy-friend hardly ever contributes to the maintenance of either her or the children.

Soekie conforms to the general rule of taking children to the Red Cross Children's Hospital if they appear to be seriously ill and if she is able to afford the bus fare. Her rationale for this therapeutic management is that the "Guguletu clinic is just for Blacks, so it is not as good as the Red Cross ....they are quick there and never rude..."

When asked if she was satisfied with the treatment itself at these clinics, she persisted in her opinion, phrased as follows:

"There is nothing for our problems but drink."

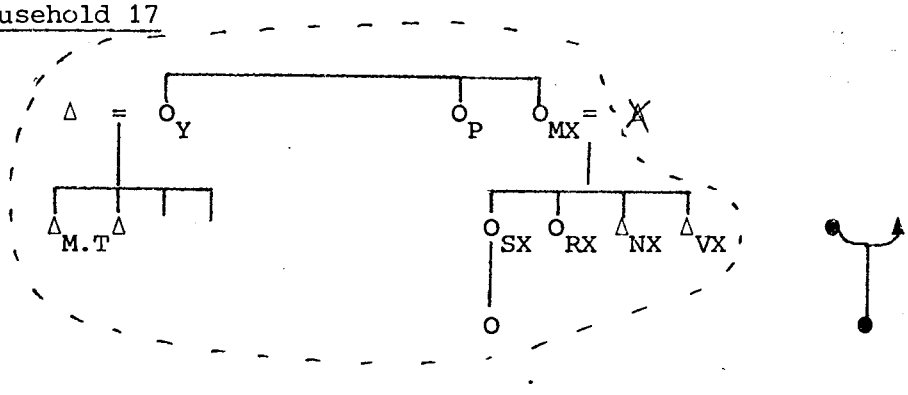
Perhaps this was partially an advertisement for the surrounding customers, but it also appears to be the opinion of many other informants who were trying to find relief from their financial problems.

A number of important aspects of health care are highlighted in the above example: in her matrifocal household Soekie bears the brunt of responsibility for the children's welfare, whereas in patrifocal households, the husband and elder sons, along with other financially supportive members appear to pool resources for the benefit of all the members. She also expressed an awareness, shared by many others, of how closely their position in society is associated with the sort of attitude biomedical staff and practitioners have towards them. In general it can be said that the working class people who make up the greater percentage of Guguletu residents, expect not only politeness but a sense of concern and caring from the biomedical staff at the clinics which they attend. (See Whisson, 1978:9) and express anger when this is not forthcoming.

Case 3 : household 17 is presented as an example in which different types of illness interpretations have been made, depending on the severity of the symptoms and their time of incidence. In addition, this case illustrates the rationale behind the choice of clinic and the fact that natural and

non-natural causes are rarely confused. Another important factor brought out by an analysis of household 17 is that not all matrifocal households, such as the above two examples (households 2 and 7) are isolated units. The coping network of this household extends and overlaps to include the mother's youngest sister's family. Together they meet some of the financial needs which may be beyond one section of the family at a particular time.

Case 3 : Household 17



Mrs. M.X's husband died of TB fifteen years ago. Her older, unmarried sister left the Ciskei soon after his death and came to Cape Town, in order to seek employment, but was unsuccessful. This occurred at a time when the households of both Mrs. M.X and her younger sister, Y, were least able to be supportive, because none of their children were economically independent. It was at this time that M.X perceived herself intwaso and joined Mrs. A.D.'s diviner network in which she has become a Five-to. The elder sister, P, is past the age for domestic employment, however, she helps around the house. Living behind the house in a shack is a contract worker, his girlfriend and their baby, all of whom are illegally in Cape Town. They seem not to form part of the household unit per sé, because they have an entirely separate household budget.

S.X is unemployed and her brother, V.X. aged 13, is still at school. They, the elderly aunt, P, and the brother's baby are dependent on the mother who is a weekly domestic, the elder sister, R, who works at a restaurant and the brother, N., who has a job at Koeberg. His job was threatened at the time the survey was conducted. Many other workers were being retrenched because the nuclear power station was nearing completion and he feared that he too would be retrenched.

This was a source of great anxiety. The family claimed to be coping at the time

research, despite their earlier poverty following the father's death and the arrival of an aunt as a new dependant. Their poverty had been exacerbated by the fact that demographically all the children were dependants. They claimed that their situation has improved since the children have started working and their mother extended her supportive network beyond their kin to include Zionists, diviners and an umgalelo group (a type of supportive savings club). As a nearly qualified diviner, she is allowed to belong to the Zionist Church as well. It is usually considered wise for a new initiate to concentrate entirely upon the divination process at first, in order that they learn the ways of diviners with whole-hearted attention.

S.X.'s two-year old daughter had had swollen, scaly eyelids for three months prior to the time of conversation. Apparantly they were very itchy as the child repeatedly rubbed them. In the mornings she was unable to open them. S suspected "pink eye" (conjunctivitis) as it was rampant at the time: however, this was not confirmed by the doctor who was consulted at the Guguletu Day Hospital. S's mother has since insisted on her taking the baby to the Red Cross Children's Hospital, as the doctor at Guguletu had not given suitable medicine.

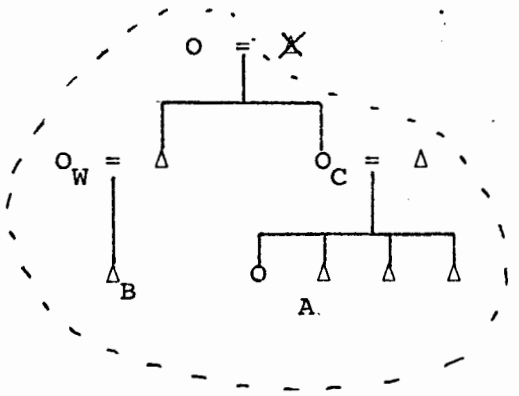
This is but one example of therapeutic management in which use is made of a range of biomedical options until satisfactory treatment is found. It also makes it clear that a Five-to does not necessarily see all physiological symptoms in terms of a so-called "traditional African medical paradigm" (Horton, 1975). Nor does she confuse natural and non-natural aetiology.

At the time of the interview, S.X. was unable to attend the Red Cross Children's Hospital because she was unable to afford the extra bus fare. Thus a temporary breakdown in therapy occurred, because of her lack of mobility. This is a problem shared not only by other members of her family, but by many of the other people in Guguletu. S's cousin, M.T. for example, has to attend out-patients clinic at Valkenburg Hospital for the Mentally Ill in Pinelands every month. Sometimes he asks his aunt for 50c. When she is unable to pay the fare, Mrs. A.D. her diviner who lives across the street, contributes because Mrs. M. belongs to her "family" of novices (1).

In this way households extend their supportive networks. Even street membership can be an important resource in times of illness or misfortune, as collections are made on behalf of those in need. Usually someone in the neighbourhood motivates the giving, and provided that one is generous, one can expect reciprocation if one becomes similarly distressed. Generosity in such circumstances therefore serves as an insurance policy.

Case 4 : household 9 is another representative example of therapy management for children's illnesses and the mother's attitudes towards Guguletu Day Hospital. It is useful in so far as it shows the manner in which specific illness-episodes are dealt with according to a mother's notions of aetiology. It also demonstrates how responsibilities can be co-operatively shared amongst members of a household:

Case 4 : household 9



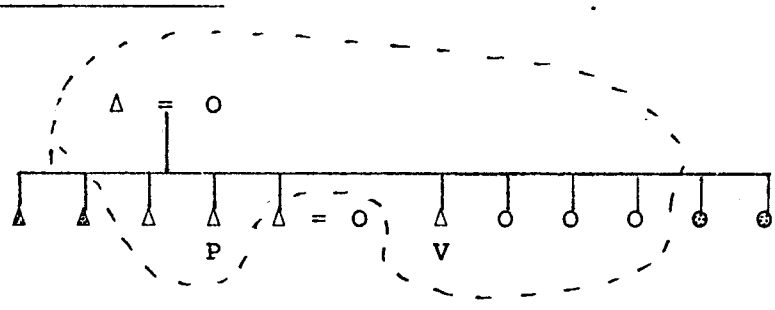
During the past few months, the 9 year-old son (A) of W.'s sister-in-law (C) had had bad toothache and was unable to eat, while her own youngest son (B) of 4 years, came out in a rash and complained of a sore throat. W. suspected B's symptoms to be indicative of measels and decided to take him to the Red Cross Children's Hospital. Her sister-in-law decided that A. should receive dental treatment at Heideveld and W., as usual, was responsible for taking him there, as her sister-in-law works as a school teacher and her mother-in-law is too old for catching buses and waiting at clinics. The latter does, however, participate in caring for the children at home. All implementation of therapeutic decisions, made together with her sister-in-law, are carried out by W. C. contributes, along with her husband, towards the payment of greatment. W's husband, however, is entirely responsible for their own child, as W. is unemployed. Both sister and sister-in-law are agreed upon avoiding Guguletu Day Hospital, because, according to them:

"You can never be sure that the doctors will see you...
they do not have time to look at the children properly.."

They are, however, satisfied with the other treatment options used for the above illness-episodes, except that they are not readily accessible. As far as their notion of aetiology is concerned: children always get measles: it is part of childhood and "just happens". (See Topley, 1970). In fact, in this instance, the rash disappeared so quickly that they changed their diagnosis and merely applied ointment supplied by the doctor at Red Cross Children's Hospital. The toothache was believed to be caused by the younger child being "too young to brush his teeth."

Case 5 : household 18 presents an example of what results from a combination of related factors such as living on the periphery of Cape Town, lack of transport and an extremely large family and poverty.

Case 5 : household 18



Key:

---- = household at time of interview

.·:·. = (dotted shading) = school children in Ciskei

P. is part of a large household with extended family networks in the Ciskei. Maternal and paternal uncles help support four of the children who attend school in the Ciskei and also spend their holidays with them. In general, supportive links between rural and urban families are useful, particularly in times of need. For instance, S., a young girl whom I met at Guguletu Day Hospital, went to stay with her uncle in the Ciskei. After she had contracted TB and received treatment at the clinic, she visited the Ciskei for four months so that she could rest in the country. This was partly to relieve the financial burden at home as she had become a dependant since her illness, and the family budget had been stretched to its limits.

In the case of household 18, besides the 4 children attending school in the

Ciskei, there are 5 children living at home, who are also still at school. P. has already passed matric, but has remained at Philippi High School to do a form of post-matric, which he hoped would stand him in good stead when he enroled for university in the coming year. Despite the financial burden, his working-class parents are adamant that their children should be well educated, so that they might later have a higher earning potential.

Because of his interest in music, P. attended an evening concert at the University of Cape Town's College of Music. On the way there, he was drenched in a rainstorm and spent the entire evening in his wet clothes, only to get even wetter en route home. By the following day he was running a high fever and his "cold" had deteriorated to an extent where he had difficulty in breathing. At this point he thought he must have a virus. According to his explanatory model, the virus, the drenching and the cold were unrelated; however, lowered resistance did appear to be tacit in his explanation.

Because P. is studying and has not yet been initiated into manhood, his mother is in charge of therapeutic management. A private doctor was chosen by his mother for several reasons: firstly, because of the seriousness of his condition, she needed immediate and reliable help, which could not be ensured, in her opinion, at Guguletu Day Hospital. Secondly, she decided to choose a private doctor whom she knew well by reputation, whereas if she had gone to Guguletu Day Hospital, she would not have known who would attend to her son.

This example is representative of households which are continuous and mutually supportive. Households which are able to rely on the support of an extended family have far greater financial and emotional security. It is also apparent that householders to a large extent have a clear understanding of natural illness aetiology and that appropriate biomedical therapy is sought. The reason that P and his mother chose a biomedical doctor, was because it seemed the obviously appropriate option. According to them:

> "Herbalists can also treat fever, so can amagqira, but this fever was the result of a virus and a cold, so it needed a medical doctor."

P.'s decision not to go to hospital, despite the doctor's recommendation, was shared by his mother as they both considered hospitalization an unnecessary expense. Once again cost of treatment was a key factor influencing

therapeutic management. Despite the cost, however, most informants claimed to prefer chosen medical practitioners to designated clinic doctors in times of serious illness. Under these circumstances patients prefer to know a doctor personally or to feel sure that he has a good reputation. Reputations of all doctors are quickly established (Whisson, 1978 : 8). Once doctors have fallen foul of a patient, the news is shared with their network of family and friends. For example, a private doctor who was perceived not to show due concern for an elderly woman suffering from "a stroke" and who made little effort to get an ambulance quickly, is widely criticized. In the same way, the doctor at Guguletu Day Hospital who failed to refer I's husband to a hospital for a tonsillectomy, has also become well known for his error, particularly as a private doctor was later shocked by the neglect. The incident merely helped to confirm in the mind of I's friends and relations, the widely held low opinion of the clinic.

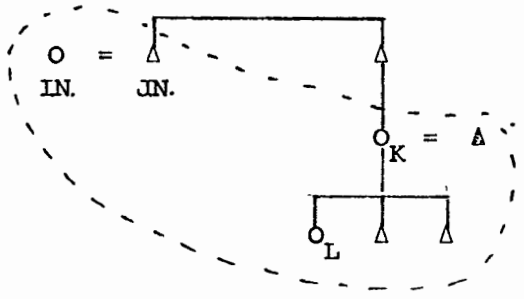
Familiarity with a particular healer is an important factor. In Household 12, for example, an elderly "Coloured" woman emphasized that she does not go to the Guguletu Day Hospital because she is treated "like a Black". She therefore only goes to "her own" doctor in Heathfield, because "he knows her". She also complained that if the nurses at Guguletu Day Hospital did not know one, they did not put one's case forward, even if it was urgent.

The particular private doctor chosen by P.'s mother was close-by. Accessibility to biomedical doctors in emergency situations is of great concern to residents of Guguletu. For example, when the pain of cancer had been felt by Mrs. A.D.'s mother for a few days, and it had shown no signs of abating, Mrs. A.D. and her eldest sister, M., had to walk with her mother to a private doctor. They were unable to afford a taxi as the consultation fee was R8. In another instance, an elderly woman, struck down suddenly by a heart-attack, had to be taken to a private doctor in a taxi. The doctor concerned, after much further delay, phoned for an ambulance.

Doctors' home visits are too costly for most people to afford, and it is also not policy for clinic doctors to make home calls. The nursing staff at Guguletu Day Hospital, however, do make rounds in some areas of Guguletu, enquiring as to whether anyone is ill.

Case 6 : household 21 presents an interesting contrast between the illness-episodes of husband and wife. It clearly demonstrates how important rest is in the treatment of minor physical ailments such as a sprained ankle, in this instance. Despite the fact that Mrs. I.N.'s retired husband has arthritis, he views his condition in a less serious light than his wife, who is the breadwinner and therefore unable to stay at home due to the financial dependency of other household members. The example also demonstrates how minor ailments can deteriorate and be re-interpreted by the sufferer as having non-natural causes. This was an understandable course of action for Mrs. I.N., who in perceiving an underlying cause for her illness, was able to justify abandoning her responsibilities.

Case 6 : household 21



Key:

∴ (dotted shading) = absent from household at time of interview

After Mr J.N. had developed arthritis, he changed his job from dockworker at Simon's Town harbour to cleaner at Fish Hoek Municipality. Eventually both the work and commuting from Guguletu to Simon's Town became too much for him and he was forced to retire because on some days he was almost crippled with arthritis. His wife, who also received minimal education, works as a char. Her earnings, together with her husband's R50 pension, which he receives every two months, make up the family allowance. With them lives J.N.'s niece, K, her husband and 3 children. At the time of the interview K's husband was in the Ciskei renewing his work permit. When the husband is away the household finances are seriously jeopardized. The wife, and 3 children, who are illegally in Cape Town are to a large extent dependent on Mrs. I.N. The situation is made more serious by the fact that K's daughter, L, is severely crippled and requires biomedical treatment and constant attention. The full burden of the financial worries rest upon I's shoulders, because her husband, aged 78, considers himself too old to be held responsible. Despite I's unhealed ankle and headaches, she

continued to take charge of the household. It is enlightening for an understanding of intwaso to note that in August 1981, Mrs. I.N. perceived herself to be called by her shades to become a diviner. Following their wishes, she left for Zimbabwe in search of a well-known healer, to whom she felt bound to apprentice herself. In this way she felt justified in putting a great deal of distance between herself and the stresses of her household. In so doing she gave meaning to her perceived sense of distress. This aspect will be discussed in greater detail below.

On the other hand, Mr. J.N. considers his severe arthritis to be caused directly by old age. He has had little biomedical treatment for his symptoms, because although the injections which he received at Guguletu Day Hospital were effective for a time and were inexpensive, the pain returned. Despite the pain, he is satisfied with his lot, because he regards his ailment as part of the natural process of ageing. He, unlike his wife, is under little stress, as he spends much of his day sitting in the sun, resting.

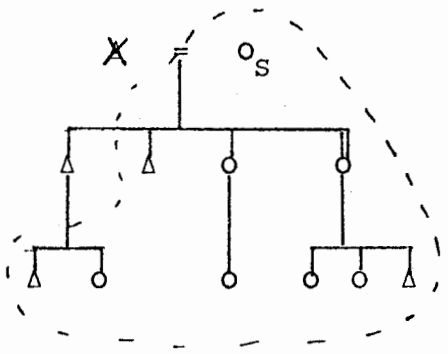
It appears to be quite common within the sample of informants approached that when the breadwinner of the family becomes ill, there is usually little opportunity for convalescence. This factor has considerable relevance for an understanding of why people living in Guguletu are prompted to interpret and explain their problems in terms of an ancestral calling (see Chapter 5). For this reason, the extent of the problem is sketched in the following vignette and elaborated in Case 7, which consists of a comparison of households 4, 5 and 8.

Elsa's mother looks after her children, and her sister's children in the Hofmeyer district in the Ciskei, while Elsa works as a domestic servant in Cape Town. She was forced to leave home when her boyfriend and father of her children, ceased to send remittances for their support. Her six sisters are in a similar position and are working in other urban centres. Together they are responsible for their family's livelihood. Because Elsa could not afford to lose her job, her severely sprained ankle had been in the same condition for four months. Although her employer had been sympathetic, she had not had a chance to rest it sufficiently.

Susan (household 4) was in a similar position as she is a member of an isolated

matrifocal household and like Elsa, was one of the key breadwinners. Susan, however, pushed herself to the extent where her condition deteriorated so far that she collapsed. The result is that she is incapacitated.

Case 7 : household 4



Susan has worked in hotels and restaurants all her life. Until a short time before my conversation with her, she, along with her younger daughter, was employed at a hotel on the Foreshore. Despite being in her sixties and suffering from severe arthritis, a common ailment in my sample, she rose early each morning in order to be in time for work. Since her husband died four years ago, there has been no one to help support her children and grandchildren, who live at home. None of her daughters have husbands or boyfriends who help to support their children. The other breadwinners in the family are her eldest daughter, aged 30, who cleans twice weekly in Claremont and her son of 27 who works at Epping Municipal market. All earnings are pooled, simply to make ends meet.

Susan was extremely concerned that she would never again be able to work, as three weeks before, she had collapsed at the hotel and was taken to Conradie Hospital in an ambulance. She was diagnosed as suffering from a bleeding ulcer, caused by taking large quantities of codeine for pain over a period of 6 months. Susan was bery bitter about this, as the clinic doctor who had treated her for pain the past had never warned her of the danger of taking an excessive dosage of codeine over an extended period.

Susan was at the time of the interview, resigned to her illness as she believed that she had done all she could to relieve her suffering. Over the past months, she has tried to organise a pension, but claimed that she had not yet received a reply. Another problem faced by Susan as well as many other residents, as mentioned before, is her present lack of ability to attend

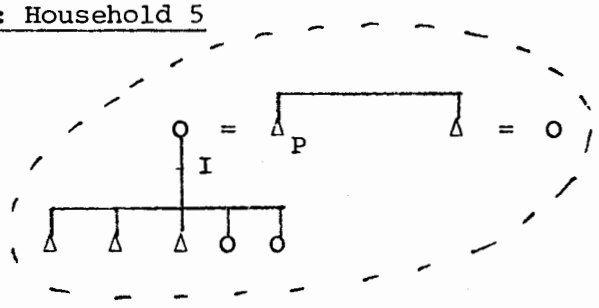
medical examinations at Conradie. She is too ill to walk to a bus stop, and the family is unable to afford any other transportation. Despite appeals made by Susan, an ambulance was refused.

Susan was in charge of her own therapy, and no one in her family was able to take her for treatment, as they were working. Although her husband used to help pay for her expenses, she was at that time entirely dependent on her children for support. Susan had never felt the need to consult an igqira because Zionist church membership filled her spiritual needs.

This case is valuable in that we see how Susan's illness was iatrogenically (Illich, 1977) caused by taking excessive quantities of codeine over a long period of time. It also demonstrates that Soekie's comment concerning the tendency of biomedical staff of the clinic to hand out "aspirin" or other less mild "pain killers", is borne out in other cases. It also shows how Susan coped with the social effects of illness by seeking the support of Zionists. Because she realized that her condition was largely irreversible, she dealt with her bitterness through prayer and managed to attain a feeling of resignation. Amelioration of the effects of her illness was the main reason for her belonging to the emotionally and to a lesser extent, financially supportive Zionist Church.

Household 5 highlights the problems involved in having to return to work without sufficient time to convalesce after a tonsillectomy: in addition to doing heavy labouring, Irene's husband Paul also had to rise early each morning in order to catch the commuting train to Simon's Town.

Case 7 : Household 5

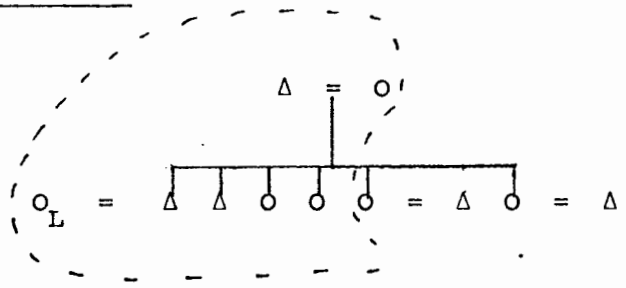


Paul is the key breadwinner and could not afford to risk his job as he is responsible for the welfare of 4 children. All but the eldest, aged 20, who does occasional gardening, are still at school. The two boys of 19 and 18 are in standards 5 and 7, respectively; while the two girls of 16 and 9 years of age are in standards 6 and sub B, respectively. Although Paul has

worked at the docks since 1972 he still earns R200 a month. According to him, the work is "all right", but he's "a bit tired" after his operation.

In household 8, Mrs. A.D.'s daughter L's father-in-law, aged 53, returned to his night-watchman's job as soon as he had left Groote Schuur Hospital after a stomach operation. In so doing he went against the doctor's recommendation that he stay at home. In this case the operation was more severe than in Paul's and L, a matriculant and nurse-aid, suspected that he was suffering from cancer, because of the symptoms he exhibited.

Case 7 : Household 8



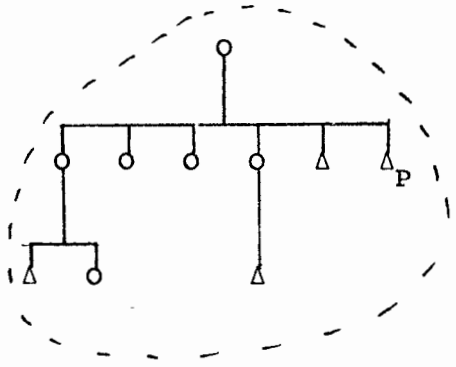
He returned to work not merely because of the reliance of his family on his income, but because of a sense of duty as he is head of the household. By working he was able to feel useful and he paid less attention to his discomfort.

In the above examples, the sufferers have been unable to adopt sick roles because they are the breadwinners: Susan, for example, pushed herself, despite her arthritis, to do her cleaning job, dulling the pain with codeine, resulting in further damage to her health. Elsa weakened her already twisted ankle by fulfilling the demands of her domestic work, while Irene's husband and L's father-in-law continued to work immediately after their operations.

Case 8, consisting of households 1 and 12, is presented for a number of reasons. It shows that residents appear to have an understanding of the aetiology of retardation and that they try to deal with the effects of the illness as opposed to treating the symptoms themselves. The difficulties involved in coping with retarded members, particularly in matrifocal households are also highlighted. In households 1 and 12, the sons are regarded as being "touched since birth" and despite the family's lack of technical control over their condition, they are not perceived to be ill from non-natural causes. The mothers, however, are extremely concerned they they

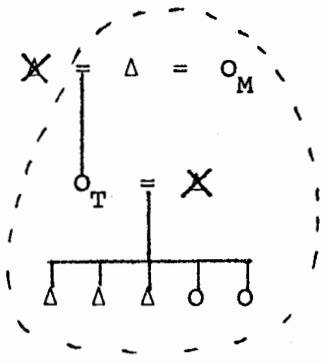
will always be economically unproductive. They have unsuccessfully attempted to find sheltered employment. Nurses at Guguletu Day Hospital who were aware of the problems for families which are created by completely unoccupied people, started a garden in which retarded and mentally ill patients could work each day. For various reasons, mostly financial, this venture came to an end.

Household 1



This matrifocal household consists of 4 daughters, aged 30, 19, 16 and 14, respectively. Both the eldest daughters have babies; the youngest baby being 1 month old. The eldest son is 25 and the youngest P, who is 21, is retarded. Given this demographic range, only the mother, eldest daughter and son are able to work, because the 19 year old daughter is nursing a baby and the other daughters are either at school or unemployed. It is understandable that having a son who is unable to look after himself is both a burden on others and a concern for the mother who expressed anxiety over what would become of him after her death.

Household 12



M's daughter, T from her first marriage to a man classified as "Coloured" and 5 grandchildren, aged 17, 15, 13, 12 and 10 have lived with her since the death of her daughter's husband. She was at the time "waiting for a

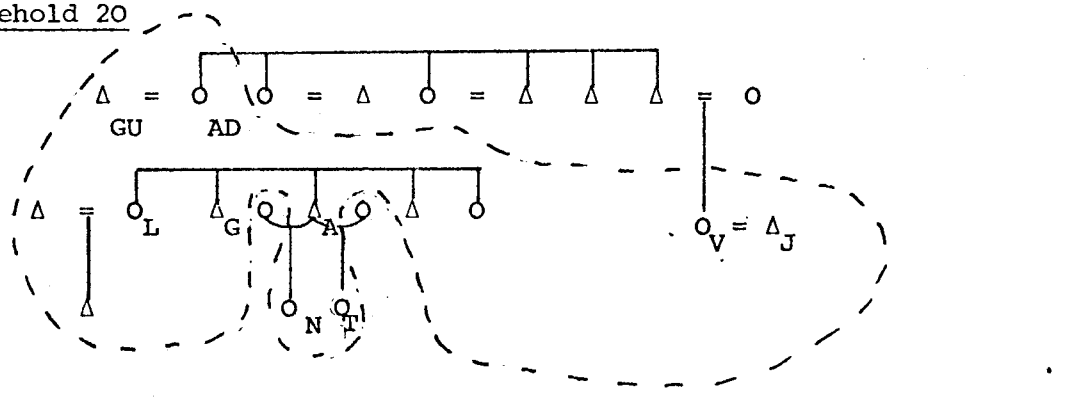
house in Mitchell's Plain", because she too is classified "Coloured". The eldest of her 5 children was described as being "nie reg in die kop nie" (mentally unstable). He is incapable of attending school and the family find it very difficult to keep him occupied. It was claimed that whenever the moon was full he became quite uncontrollable, for instance: one occasion he has wandered away for days on end. As he grows older he was said to become more and more troublesome: "Daars geen plek vir 'n kind soos die by Guguletu nie; nou wat moet 'n mens maak?" (There are no places for children such as him in Guguletu - We do not know what to do?)

It is apparent that retardation which incapacitates a family member is a very real problem, not only in terms of productivity, but also home-care. In isolated, matrifocal households, the inability of a one household member to contribute to the budget has a dire effect on their overall living standards.

An important factor made apparent in a study of household 12 is that retardation is not believed to be curable, for instance although M's second husband is an inyanga who specializes in fortune-telling, it was considered inappropriate for him to give advice on such a condition. The family has also not used prophylactic measures as these were considered inappropriate as well. The importance of prophylactic measures was, however, emphasized by other householders both for health maintenance and in times of misfortune and illness. The neglect of the shades is averted by the custom of ritual sacrifices at appropriate points in the life-cycle. Bewitchment and bad luck are believed to be held at bay if the ancestral shades "brood over the family". Others follow more elaborate prophylactic measures.

Mrs. A.D., Case 9 : Household 20, for example, gives herbs to her son A, her niece V's husband J, and her own husband, G.U.

Household 20



All three had been retrenched from construction on Koeberg and thus the family finances have been severely affected. Everyone in the family believes that they are suffering from "a run of bad luck". At the time of research, A had spent all his earnings on the deposit for a Hi-Fi set which he had recently bought on the hire-purchase system, a week before he was retrenched. Almost concurrently with these set-backs, A's girlfriend left their baby with his mother, who was at the time also having to look after Natalie, another one of A's children.

Tingling herbal washes are believed by Mrs. A.D. to help keep away the feelings of despondency associated with bad luck and to help her family to "see clearly". In A's case, however, Mrs. A.D. believes that the herbal washes are only a stop-gap until he undergoes circumcision. She expressed the hope that after fulfilling this custom of circumcision, the shades would be more inclined to protect A from further foolishness.

Another prophylactic ritual was performed for her son, G, who was at the time working at a beer-hall in Guguletu and drinks excessively. As he had already undergone circumcision without any noticeable affect on his behaviour, his father, Mr. G.U., decided to slaughter a goat for him. This custom, called umbeleko, is loosely translated as "the killing of a goat for the child's blanket". In other words, it is a protective measure aimed at forestalling illness and misfortune by calling upon the shades for protection. This takes place after birth or by the time the child is 2 years of age. Today the ceremony is regarded by most informants as unnecessary, unless the child suffers misfortune and it is suspected that the shades are offended by neglect. According to a few informants, however, umbeleko is extremely important, because only then is a child "born socially." A prophylactic ritual today rarely performed during childhood or in later years, is the amputation of the first section of the little finger belonging to the left hand. (It is mentioned only the sake of completeness.)

Circumcision, however, is regarded by most Guguletu residents as an essential prophylactic. If it is neglected, the young male is believed to become ill or morally degenerate. Mrs. A, a trained nuring sister and midwife summoned up their opinion as follows:

> "I believe in some of the Black people's customs like circumcision. It is psychologically good. The Jews

> and the Muslims do it and we believe that it makes the boys responsible, because they think, 'Oh, I am circumcised; now I am a man!.. The other customs are to me, not so important."

Female initiation, on the other hand, rarely, if ever, occurs in an urban area. Most urban residents scorned it: however, an elderly female informant who had grown up in the Ciskei, claimed that sometimes if one did not have a goat killed at puberty, one could later become ill.

Thus one sees that adherence to some customary prophylactic measures does not necessarily mean the same thing to all parents, nor is it given equal weight by all those, for example, who are initiated. It is performed for a variety of reasons besides the fact that it is believed to be necessary for the development of an adult sense of responsibility. Today education is considered far more important. If one is not initiated, however, it is considered that one might be regarded in some situations as being "less than a man (Mayer, 1971) or less than a woman."

Many other prophylactic measures for illness mentioned by informants fall outside the realm of ritual and within the genre of "old Wives Tales" such as wearing earrings for poor eyesight, steaming babies at birth to ensure they breathe properly and keeping all doors and windows closed during winter, in order to prevent colds and influenza, to mention a few representative examples.

In some cases, neglect in fulfilling customary rituals, particularly at the transition stages of the life-cycle, is believed to result in either illness or moral breakdown. Thus it is important to emphasize that successful therapy management includes prophylactic measures; especially the fulfilment of customs related to initiation into new life-phases (rites de passage)(Van Gennep, 1960). A realistic focus of therapeutic management must therefore emphasize both <u>health</u> maintenance and the treatment of disease.

My treatment of the above-mentioned illness-episodes has been rooted in the social and temporal context, in order that their aetiological interpretation might be contextualized. In each instance, a limited range of therapeutic and prophylactic options were used. Informants highlighted natural as opposed to non-natural illness conditions, for which the technical control

of biomedical therapy was considered appropriate. Janzen et al.(1981) have argued that an understanding of natural causation has been underplayed, although it is very much part of so-called "African therapeutic management."

Before we explore examples of illness episodes, perceived to have underlying non-natural causes and for which a range of treatment options were used, it should be demonstrated that atitudes towards indigenous healers range from outright disrespect or mere tolerance to unquestioning faith. The following illustrative quotations give an idea of the range in attitudes of people, living in Section 3, towards indigenous healers.

> "There are many different sicknesses and you use different healers for them... you do not go to a medical doctor for cancer, you go to a herbalist, but a medical doctor can help you for measles or TB or such things. You must go to an igquira for amafufuyana, because these things are sent to you by someone who does not like you, or he gets an ixwhele to send them to you. Other things can be sent such as the tikolosche and impundulu. If you do not go you will get mad. You must also take intwaso to the amagqira who will follow your ancestors' wishes."

> "In Cape Town people do many dirty (bad) things, we need the amagqira to help us."

> "We can go to Zionists or the Amagqira. The Zionists are really amagqira, many do both types of healing but Zionists just don't admit that they are the same as amagqira."

> "The amagqira are allright but they cost more than the Zionists."

> "I don't go to any of those amagqira. The Iinyanga just tell fortunes and give herbs, so they are allright. I don't go to faith healers, any of them, I don't believe in their rubbish."

> "We never use amagqira, none of them tell the truth, they just take your money."

It becomes apparent that the distinctions between categories of non-biomedical healers, although emphasized by some, are collapsed by many informants who emphasize their similarities. For example, spiritual healers such as Zionists and the amagqira are regarded as being similar, as are the iixwhele and iinyanga.

Educational level does not always determine that attitudes towards indigenous therapeutic options will be negative. An astute nursing sister living in Guguletu expressed her philosophy of amagqira and life, as follows:

> "I am not interested in personally going to the amagqira, because some do not tell the truth, they often accuse your neighbour of doing this or that to you: I don't like that. Psychologically the true igqira can help you, though I get my spiritual needs filled by belonging to the Methodist manyano. We wear a uniform and it is like our club, you can say. Maybe others think we too are ridiculous, but I enjoy it. It is the same for the amagqira, it is like their uniform when they dress for iinthlombe. I respect the next person's feelings, so who is to say they are wrong and my way is right?"

Both this nursing sister and others at Guguletu Day Hospital complain about the way some doctors use expressions like "Black person" in explaining symptoms to patients. It is regarded as yet another term of condescension:

> "The Black patients come here (to G.D.H.) because they want help from a medical doctor. They know that they can go to an igqira if they wish to."

It is thus well-understood by these nurses that popular explanatory models include both natural and unnatural causation and that they are never confused, except by outsiders who see the options as being <u>competitive</u> as opposed to <u>complementary</u>.

Salutary attempts at "understanding the customs" obviously do not meet with much respect from "Black" nursing staff, not merely because they are believed to "hold back their people" but because they are not fully understood. Another nurse claimed:

> "You must know <u>why</u> we do these things sometimes (go to amagqira, for example) then only is it meaningful to talk of our customs."

To a large extent, it appears that belief in the "old ways" is respected by educated people, not purely because of their efficacy but also because they are linked with Black identity.

There is a strong realization that the clinic doctors do not:

> "go deeply into the people's problems... all these people have social problems, which we do not treat."

Many nurses see some of the amagqira in the role of listener, comforter and supporter for "social problems": however, they always qualify their statement that others are mere charlatans. Many informants, as mentioned above,

have made it clear, however, that the amaggira who are "no good" have few initiates and regular clients. Their bad reputations are well-known and no one takes them seriously. Unfortunately, in the process of acquiring that reputation, people do suffer, but the same can be said for the bio-medical doctors consulted by Guguletu residents.

The usefulness of the statement:

> "It's when people have a sense of losing control of a technical level that they begin to look for a wider, causal, explanatory theory, and they look then to the social and moral domain."
>
> (Comaroff, 1981 : 430),

will be explored by the following vignettes which show illness-episodes for which a range of treatment options were used. The validity and acceptability of Comaroff's proposition will be tested, however, in Chapter 5 by the formulation of an hypothesis to the effect that the social context is the determining factor for aetiological diagnosis as to whether a symptom is natural or non-natural.

TB will be held constant and used as a control for therapeutic management in a variety of social contexts. In this chapter, however, a wise range of other symptoms and the attendant therapeutic management will be analysed, to provide a broad-based background for the understanding of the therapeutic management of intwaso and the rationale for joining diviner networks.

Case 1 : household 2 is again introduced as an example of an illness-episode which was thought to have an underlying dimension of bewitchment (refer back to p. 58 for household diagram) S.X's 5 year-old son was hospitalized at Conradie for two months during the previous year, on account of his high fever and constant crying. Home-care such as keeping the child cool did not help, and when the symptoms became severe she sought medical help. At that time S had no notion of what was wrong with him, until the child was diagnosed as 'meningitis'. After the child was discharged, S took her son to an ixwhele who said that his sickness had been caused by a worm, which had crawled from his stomach into his head. S was extremely dissatisfied with this explanation and refused to pay for the emetics he offered her. She had been quite satisfied with the treatment at the clinic, but could not understand why the child should have become so ill.

since the unsuccessful episode with the ixwhele S.X. has dealt with her own anxiety over her family problems by attending the Zionist Church. Because they are emotionally supportive, they help lessen her anxiety.

In the above episode and the one that follows (Case 7 : household 5, refer back to p. 73 for diagram, the diagnosis from natural to non-natural is changed as a result of unsuccessful medical treatment and the emphasis is shifted to highlight possible underlying causes.

At the end of 1980, Irene's 18 year old son, while playing a soccer game, hurt his knee on the gravel surface of the field. As the wound was severe, Irene took her son to Guguletu Day Hospital, where it was bandaged. Instead of healing it became infected and Irene thought it wise to take Mark to Conradie Hospital. His leg was encased in plaster for two months, during which he suffered such great pain that he cried out aloud frequently during the night. When the plaster was removed, his entire leg was still very swollen. Irene's friend advised her "to waste no more time" with medical doctors, and introduced both her and her son to a Moslem doctor whom she knew personally (Irene described him as "a sort of ixwhele"). On agreeing with her friend that Mark may perhaps have "trodden on some poisonous track left by someone or something", she visited the "ixwhele" who held her son's leg over a fire made of brown paper and steamed it for about half an hour or longer. He then covered his leg with ointments and within a day "the leg began to drain of poison". They continued to keep the leg uncovered, except for the layer of herbal ointment, and within a month it was healed. The family was most relieved as Mark had suffered much pain. Whether the therapy of the ixwhele succeeded where medical doctors had failed, or whether he merely intervened at a stage when healing was occurring naturally, is beyond the scope of this discussion, although it is an important medical consideration.

In this example we see how the episode is re-interpreted as being non-naturally caused when treatment is ineffective. According to Irene, how else could one understand why a healthy boy became so ill as a result of a mere fall. If he had responded to treatment, there would have been no need to shift the emphasis in an understanding of aetiology. In many instances aetiological interpretations are changed more than once during an episode, from natural to non-natural and back to natural as a result of unsuccessful treatment from an indigenous healer. Case 3 : household 17 (refer back

to p. 63 for diagram) is also used to demonstrate the importance of bringing aetiology and the results of therapy into alignment.

MT suffered a severe injury during a soccer match between his own club and the White Spurs, during which he was "tackled" by an opponent. He was sent to Groote Schuur Hospital immediately in an ambulance, but after he was discharged "he was still not right", according to his mother. At the suggestion of a doctor at Groote Schuur, he was hospitalized at Valkenberg for a month, after which he attended their out-patient's clinic for chemotherapy. This treatment did not help his condition as he was either violent or sleepy, depending on whether he took his pills. At this point, his fellow team-members began to suspect that one of their opponents had sent amafufunyana (little fighting men) to MT because he was jealous of his ability to play soccer so skilfully. The amafufunyana fighting within his body were seen to be the cause of his irrational behaviour. On the advice of MT's friends and his family, his mother decided to take him to a faith healer in Mount Frere, who has a very good reputation. But after her treatment, MT continued to behave "like a snarling dog", according to his mother. These symptoms only confirmed everyone's suspicions that it was amafufunyana. She explained that treatment had failed up to that stage by emphasizing that only amafufunyana were able "to hide from doctors so cleverly". As a last resort, his mother took MT to an igqira in the neighbouring township, but once again the consultation was unhelpful because the healer "had no power."

By this stage, MT's behaviour had deteriorated as he had not been attending Valkenberg for medication. His mother came to the conclusion that his illness could be best helped by medical doctors, because the amafufunyana had made him mad (phambana) and therefore beyond the therapeutic reach of most indigenous healers. He is now well-known in Section 3 and I was told "not to worry about him because the poor boy just minds his own business."

The categories "natural" and "non-natural" are therefore not necessarily discrete and can be re-interpreted within the course of a single illness-episode. Each category is sub-divided into "serious" and "not serious". These subdivisions in the perception of illness are important determinants of therapeutic management, and are also continuous and subject to

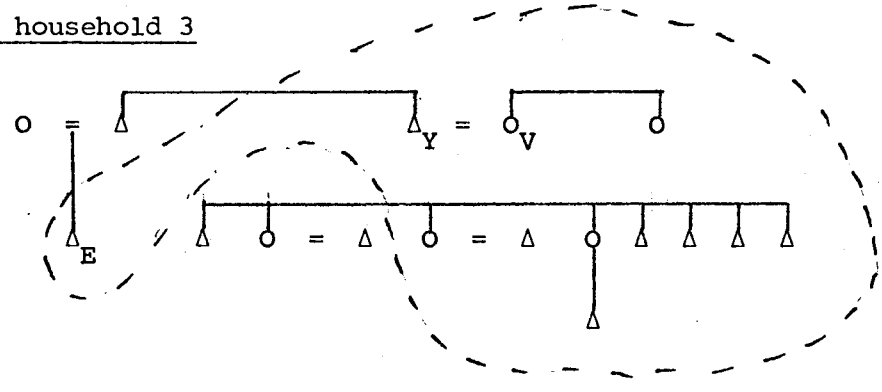
re-interpretation. Non-natural illnesses are usually perceived to have "something behind them", that is, they are believed to be either morally deserved or undeserved. According to informants, when family or sufferer perceive this illness to be non-natural and serious in condition, he goes to a medical doctor for an operation, injection or medicines because these healing techniques are considered to work quickly and effectively. The igqira, for example, does not profess to be able to heal in these ways, although they can tell why people are sick and help to appease their shades in order to prevent further illness. Both healing options are therefore used. If, however, an illness is perceived to be non-natural and not serious in condition, then it may be possible to consult only an igqira.

On the other hand, if a serious illness is first perceived to be natural and a medical doctor is unable to help, the diagnosis may be altered, at least temporarily, in an attempt to obtain help from an indigenous healer. Natural illnesses which are not considered serious are treated at home with preparations obtained from a herbalist or chemist.

An analysis of the popular explanatory models is indicative that cognisance was taken of natural causes and that there was a high degree of facility in employing biomedical taxonomy.

As mentioned above, not all non-natural illness is morally undeserved due to "bewitchment"; some are believed to be the result of the ancestral calling. This was the interpretation for example, in the following case.

Case 10 : household 3



Both V, aged 54, and her husband, Y, aged 57, were born in Guguletu and have worked in Cape Town all their lives. V.'s husband is employed at Groote Schuur Hospital as a cleaner, their "adopted" son E (her husband's nephew) aged 25, works at a factory, while their own son of 21 works at a

steel company. Seven family members are dependent on their earnings.

Two years ago, E. became very weak and out of breath. V., concerned about his condition, immediately took him to an Indian private medical doctor in the area, who diagnosed a "heart murmur". He was referred to Somerset Hospital, about 15 kilometres away, to be treated for his condition. V. travelled regularly to see him. She was particularly troubled at this time by fits of anxiety, particularly because they were finding it extremely difficult to make ends meet without the son's earnings. V, for example, was unable to "finish the house", that is, to electrify it as planned or afford a telephone. Nor was she able to ensure her 4 sons, aged 8 to 19 had school books and uniforms.

At this time she was unable to stop crying and for days she lay immobile on her bed. On questioning, this episode was found to coincide with menopausal distress, which was probably worsened by their emotional and financial concerns.

Despite the money shortage, her husband insisted that she too consult a private doctor in Guguletu. She was referred to Valkenberg Hospital where she was kept for observation. At this stage her condition deteriorated. According to V, she was made more unhappy because she "did not know what was happening at home." After two weeks she was discharged but had to attend Valkenberg out-patients' clinic each month to fetch tablets.

V. became convinced that her misfortune was due to some underlying reason and decided to join a Zionist Church for spiritual help. By this time, she began to claim that she dreamed of her shades who were calling her to become a diviner. Her husband, however, did not wish her to consult a diviner because the process of initiation is time-consuming and would involve a temporary separation between himself and his wife. It also involved heavy costs, besides which he did not wish his wife to belong to a diviner group, "some of whom have a reputation for dancing and drinking all night, whether their husbands like it or not."

The Zionists, however, did not help V and she continued to dream of "white beads and the killing of a cow", although no particular ancestor (ityala) presented itself to her. At the same time, she complained of umbilini ihlaba, a pain, which felt like a "sharp knife" in her body and convinced her that

she was suffering the symptoms of diviner's sickness, intwaso. This final complaint persuaded her husband that she was "really ill" and he assented to her request that she be taken to "Gadabi". The chosen igqira "followed her dreams" and agreed "to sacrifice for her father's side of the family." In other words, she appeased her own paternal ancestors first, as is customary, and thereby answered the call. Gadabi performed "invuma ukupha" which means "to accept the illness by slaughtering to the izinyanya", thereby indicating that she was indeed willing to carry out their wishes.

For some time she felt better, but later she dreamed that she must "kill for her mother's side as well, otherwise the shades would not be satisfied". As her mother belonged to the D clan, she dreamed that Mrs. A.D. was the one "to do the second cow", because they had common ancestors.

According to informants, it is necessary in some cases to go to more than one diviner, depending on what the shades desire. The igqira who is temporarily forsaken should not be offended, ideally speaking, although this does occur if the situation is not handled tactfully by the novice. Gadabi was satisfied that this was what she must do, because if V. ignored the wishes of her izinyana, she would become mad (phambana). In this way V once again extended her supportive amagqira network in an attempt to find inner peace.

V's husband was prepared to pay for cows, not merely goats, which are sometimes used in lieu of the former, when the sufferer and the family concerned are unable to afford the more prestigious and costly animal. If the ritual succeeds in alleviating the condition, then the goat (and other relevant symbols) are believed to be equal in symbolic value to a cow. If, however, the ritual is not successful, then it is often said that the ritual was not performed sufficiently carefully, or that it had deviated too far from the "old way". In the urban areas, the sacrifice, for example, has to occur in a symbolic kraal, made in the backyards with the necessary type of green foliage of the Mnguma tree on which the meat should be served. In circumstances where it is possible to return to the initiate's home in the rural areas, the sacrifice is performed where the shades are brooding over their descendants and where it is still possible to perform the customs (amasiko) in the "old way".

After V. had had two cows sacrificed on her behalf to her ancestors, and she had regularly attended iinthlombe for two years, she

progressed to the stage of "Five-to". At this stage she was allowed by the presiding igqira to re-affirm her links with the Zionist Church, because her shades were satisfied and appeased.

V. attributed her returned health to the fact that she had fulfilled the necessary ritual, and that her shades were pleased with her. She did not, however, rule out the possibility that it would be necessary to carry out further sacrifices "because the process of intwaso must continue to be followed if one wishes to move forward, not backward, in the way of the amagqira".

In this example we see how the shades were mobilized to justify the adoption of a sick role which enabled V to expand her network beyond her household, which she perceived to be in a state of crisis; to include what will be argued below are mutually supportive networks. We also see that V's symptoms were interpreted only after hospitalization at Valkenburg as being intwaso. Hospitalization was probably the last straw in a series of misfortunes, which to use her words, "made the intwaso", present since birth, "burst out". Many informants emphasized that intwaso is "something in you before you are born which comes out later in life". The social context of intwaso is rarely emphasized by informants, who usually explain the condition according to a patterned, stereotyped process of dreams, ancestral calling and initiation. To admit otherwise would in some cases lessen the justification to adopt a new role and to be free from responsibilities during the initial training period. Intwaso is therefore commonly regarded as a calling, communicated through physical or emotional symptoms.

Another example of intwaso was occurring in Case 6 : household 21 at the time of fieldwork. It differs remarkably from Case 10 : household 3 because the illness was at first not confirmed as being genuine by the diviner consulted.

As mentioned above, Mrs. I.N., J's wife, bore the brunt of supporting not only her aged, arthritic husband, but also J's niece and her children because the latter's husband is a contract labourer, who returns to renew his contract in the Ciskei and at times is away for months on end. The niece, because she is illegally in Cape Town, is unable to secure a job and I, who is 53, privately resented her dependence. She began to dream of her shades and after much saving, she left Cape Town in order to apprentice herself to a

well-known igqira in Zimbabwe. After two months, however, she returned, claiming that the diviner she had consulted was in reality a witch. When she arrived in Zimbabwe, there was no one to fetch her at the station as had been arranged. Hours later when he arrived, he showed very little concern for her anxiety. She was later convinced that he had put amafufunyana in the medicine he had given her, because she felt more anxious after he had treated her.

On her return from Zimbabwe, Mrs. I. asked Mrs. A.D. if she would treat her Mrs. A.D. was somewhat annoyed at being first passed up for the igqira in Zimbabwe. She said to me:

> "My neighbour went to Zimbabwe because none of us (amagqira) are good enough for her sickness."

At first Mrs. AD refused to believe that she was truly called and suspected that she was "just saying she was intwaso" because she wished to be "powerful and respected". Mrs. I, however, claimed to dream every night of her izinyanya and once again visited Mrs. A.D. On that occasion she felt her izinyanya wished her to apprentice herself to Mrs. A.D.'s sister, E., who was an igqira.

This was found extremely annoying by Mrs. A.D., who told me that she was sure that F, one of her more "bossy five-to's" with a reputation for "pushing initiates around", was the reason why I. preferred to apprentice herself to her sister, E. Mrs. A.D. did not consider that her own disbelief might also have been an important factor for changed decision. She emphasized that if I. had truly wished to become her novice, she would have accepted her at her second request. Her initial refusal appeared to be largely due to her pique at being passed up for a "more superior diviner in Zimbabwe".

Mrs. A.D. eventually agreed to accompany I to her sister, but not before telling E that she suspected that I had amafufunyana, not intwaso. E, as expected by Mrs. A.D. apologised, saying that she only treated intwaso not amafufunyana, as they were dangerous and took too long to heal.

Time passed and Mrs. I. persisted, saying that she would become mad (phambana) if the wishes of her shades were not followed. E began to relent at this stage and said that she could become her apprentice. A few days later I had to leave Cape Town once again because her mother in East London had died. When

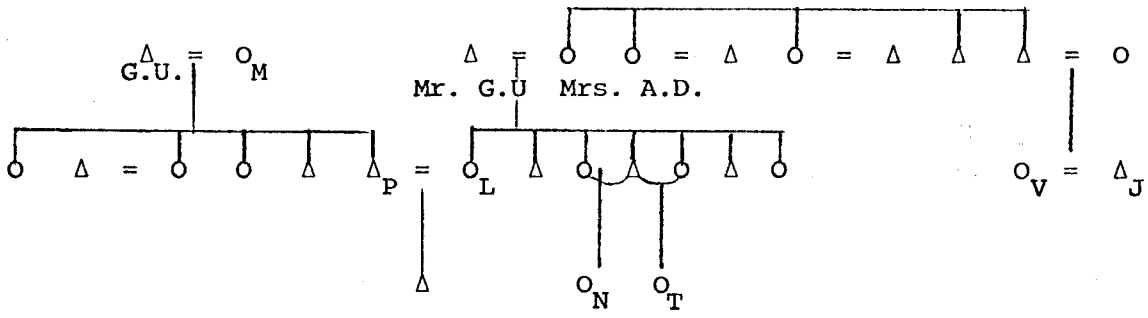
she returned a month later, Mrs. A.D. visted her rather shamefacedly on behalf of E, "to give her sympathy" and to tell her that her sister was ready to "tie the strings of white beads" indicative of the acceptance of the ancestral calling. She went out of her way to make amends for her harshness because of the circumstance of the death of I's mother. Mrs. A.D. had lost her own mother only a month before and was therefore very sympathetic. She stressed that only beer need to be brewed at her initial iinthlombe and that only later, when I. was able to afford it, would they kill a goat. Mrs. A.D. claimed that as she had had "too many funeral expenses, the izinyanya would understand the delay".

This episode illustrates the petty jealousies amongst amagqira who cannot be seen merely as an ideal stereotype, namely the caring mother. It also represents an occasion where someone who claims to be intwaso is suspected of having purely manipulative motives and not being truly ill. The doubt may, however, have existed purely as a result of annoyance, because Mrs. A.D. who had "only been trained by a diviner in the Orange Free State", felt outdone when her neighbour had come to say goodbye before going to a diviner in Zimbabwe. She also felt slighted that Mrs. I. had not considered coming to her for training as had four other people living in the street. It is also important, however, to emphasize that eventually, as a result of constant pleading, I. was accepted whole-heartedly as a "true umkhwetha". The fact that her mother also died at this time made both Mrs. A.D. and her sister very ashamed of themselves. They therefore made an exception in her case, as they occasionally do, of holding an iinthlombe before the initiate was able to afford a goat. The degree of financial resources is a very important determinant as to whether one is able to mobilize enough finances to become a member of mutually supportive amagqira networks. This will be discussed in greater detail below.

The following instance (Case 9 : household 20) is also used to demonstrate an episode of intwaso which could have been interpreted as being a form of manipulation by the strong-willed in the sense used by Lewis (1971) and Turner (1968) and not purely "as a means used by the weak to gain certain favours from the strong", an interpretation criticised by Sibisi (1975 : 56), as being an over-simplification of reality. We see how a tense family situation was alleviated by M., who expressed her dissatisfaction in terms

of the idiom intwaso. This was both an appropriate and acceptable strategy and it was more likely to be successful than open hostility towards kin. It is also useful to demonstrate that in some instances a diviner finds it wise not to question a patient's motives for perceiving herself intwaso.

Case 9 : Household 20



Perceived intwaso in M's case was unquestioned, not only because she approached Mrs. A.D.U. as one whom she respected and from whom she sought help. Not as a second choice used merely as a last resort, as in the previous example. A more important consideration, however, is that she is L's mother-in-law, with whom L. did not get on well. After she had married, A's daughter found that life in her mother-in-law's home was uncongenial because of the latter's old-fashioned ideas. Under these circumstances, A. was able to help her daughter by training M. and accepting her as her novitiate.

The reason for friction was that L. is a matriculant nurse-aide, who is both articulate and sophisticated. Although she carried out the customs of Hlonipha within the household of her parents-in-law, she did not agree with her mother-in-law's domestic organization, because she did things in the old way, having been brought up in the Transkei, with minimal schooling. When she was given training by her mother-in-law, as is customary, L. tried to teach her instead of obeying. According to L., M. was "bossy and mean" to her.

Not long after L. had been staying with her husband, M. decided to go to A. to have her fortune told, as she believed that she was intwaso. According to M, she had been intwaso for some time: however, she had only recently begun to see that her headaches and fevers were related to an ancestral calling. In the past she claimed that after she had avoided apprenticeship

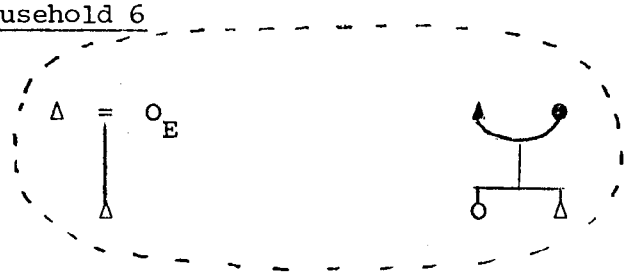
and while she had consulted amaggira, she had seen fit to disregard their advice. This was because she had wished to avoid the process of initiation (ukuthwasa). In her opinion, one shared by others, many urban diviners are frauds and she "did not wish to tell lies, or be associated with them". She considered Mrs. A.D., however, to be a true igqira who would "teach her to see clearly". She believed that both her mother's and her father's shades were calling her and that if she disobeyed the call, she would become mad. Before the onset of symptoms, which were later to be interpreted by her as intwaso, her husband had been hospitalized at Groote Schuur, after he had begun to complain of a severe stomach complaint. Mr. G.U., L's father, was also at loggerheads with the family, because her son had failed to pay any lobola for L. M. therefore suffered stress from the constant friction with L and her father. She became especially concerned about their financial position after her husband became ill. She claimed a respite from this clash of wills by approaching L's mother, Mrs. A.D., and apprenticing herself. Mrs. A.D. sympathized with her, and felt that she could not deny her help because she was a family member.

In this way M. was able to win over Mrs. A.D.'s husband and ensure that L. did not stay at her home, because she was unable to train her properly as a young wife "until she had fulfilled her ancestors' wishes". Mrs. A.D. "followed her dreams" and within a year, M. began to feel less anxious. She was incorporated into the network of iinthlombe and despite her husband's poor health she was comforted and kept occupied by her fellow initiates. L. was frequently admonished by her mother when she spoke too loudly or ignored the opinions of her elders: for example, Mrs. A.D. would say lightly "Oh L., you have such a loud voice, you are just like a man". The domestic situation in both households has become more peaceful and L. has eventually moved back into the home of her in-laws.

Case 11 : household 6 is presented as a representative example of an illness-episode which is believed to have "spreading-effects" (both psychological and physical), because the symptoms were perceived to be due to an underlying cause, namely the call of the shades. It is an interesting case in so far as we see how the recurring social problems of alcoholism and the fear to take sick-leave from a much needed job, are given meaning and expressed in terms of the idiom intwaso. Ancestral displeasure is a wife's interpretation of her husband's drinking problem. Thus the symptoms were seen as being

the result of and not the cause of their unhappy home life. At the same time, however, the onus was placed upon her husband not to displease the shades further by refusing to fulfil their wish that he consult a diviner. This is surely a tactful way of persuading an alcoholic to seek group therapy and to mend his ways?

Case 11 : household 6



E. lives with her husband and her baby. In order to defray costs, a migrant lodger, his girlfriend and baby, both of whom are illegally in Cape Town, also live with them. E. complained of having a persistent cold throughout the winter. She believed that her cold was partially due to the fact that she had to work, while the lodger's girlfriend looked after the children at home. She claimed to have had no chance of resting and getting better, because if she had stayed at home, she feared she would lose her job.

E believed that the reason for her "suffering" lies behind any natural cause because it is due to her ignoring the call of her shades. Her stubbornness, she believes, has had spreading effects, such as her husband's stomach problem, resulting from his inability to stop drinking excessively. E. consulted an igqira as to the reason for his drinking and had her suspicion confirmed that the ancestors had left their home. She believed that only a diviner would be able to relieve their "house-problems" as her husband works for a liquor outlet and always has access to alcohol. He has been attending a private doctor in Claremont, but has not shown any signs of improvement.

E. has also had "medicine from a chemist" for her colds, but it has failed to help. Under these circumstances, it is hardly surprising that E. suspected that there was another dimension to their problems. To relieve her anxiety, she was at the time attending the iinthlombe that her mother, "Nobulawo", attended as an initiate. E., however, realized that she would

have to do more than merely attend the iinthlombe if she and her husband were going to recover.

E. and her husband usually decided together on therapeutic management; however, E. insisted that her husband accompany her to an igqira for her own peace of mind, as she suspected that all their misfortunes stemmed from her refusal to become a diviner's novice. She sees their lives as being "out of balance" because the ancestors had turned their backs due to her ignoring their call. E. claimed that she would not consider getting the Zionists to heal their "house-problems", because in her opinion, they would not ultimately be able to treat intwaso. "For intwaso, you must follow the wishes of your ancestors". She admitted, however, that some other people had received successful treatment from Zionists. For this somewhat isolated family, the supportive networks of the amagqira would provide help to E., whose mother, since her husband's death, was also in a state of crisis.

From the above examples it can be seen that the non-natural dimension frequently comes into play in instances where the individual feels isolated, neglected or unable to control perceived misfortune or illness. This is particularly so in the case of some of the migrants with whom I made contact.

An elderly migrant without a pass and without a home was met at Guguletu Day Hospital where she was receiving treatment for "headaches and nerves". She complained that she also needed to see a social worker, as she lived in a shack in someone's backyard and was destitute. She described her symptoms as being a rapid heart-beat, anxiety attacks and headaches caused because she constantly feared what would happen to her as she grew older as she had no family to look after her. She was abandoned by her mother at an orphanage in Johannesburg and had never known any of her family members. She had received a little help from a Zionist group but they could do nothing more than introduce her to families who allowed her to build a shack in their backyards. She tried to repay their hospitality by doing housework, looking after their children and doing a little handiwork such as crocheting. She was unable to afford the initial costs of apprenticing herself to a diviner. This aspect will be taken up and discussed below in greater detail.

Suselina and Esther were illegal migrants, living in a shack behind a house in Section 3 (household No. 16). They are both apprenticed to Mrs. A.D. Suselina has a husband who is a contract labourer and a baby, and is therefore

less isolated than Esther who is completely alone in Cape Town. Both, however, feared constantly that they would be arrested. According to Mrs. A.D., she "is their mother as they have no other family living nearby". She has also helped them to maintain ties with their family members in the Ciskei, by accompanying them home for the initial ritual of accepting their ancestral calling (invuma ukupha).

According to both Suselina and Esther, the process of being called (intwaso) had started before they left the Ciskei. Suselina had feared that her husband would never return when he became a contract worker, and Esther was unable to support herself in the Ciskei. Esther was still unemployed at the time fieldwork was conducted, because she was unable to find domestic work. Both Suselina and Esther have temporarily ceased to attend Zionist meetings until they have progressed further in their apprenticeship to Mrs. A.D. This is done, in order that they might devote all their attention to following the will of the shades.

Tembe, a contract bricklayer, also made use of supportive networks. His amakhaya (group of men from his home area) were essential to his sense of well being, because he had no family members in Cape Town. Together they smoke tobacco and drink beer (utywala). This activity, he said, made him feel less hungry and lonely. He added that although a doctor at Guguletu Day Hospital had told him to stop smoking, because of his asthma attacks, he had no intention of doing so. As far as he was concerned, smoking and drinking with his amakhaya was "one of the only good things left" for him in town.

All four vignettes show how essential it is to have a family or alternative supporting netowrk, in order to cope in a township. Whether or not one chooses a <u>mutually</u> supportive diviner network, depends to a large extent on whether the potential initiate is able to mobilize financial support from kin or sympathetic friends. The paradox (see Chapter 6) is that because of the cost of treatment, isolated people who are in need of emotional and material support, do not have the wherewithall to pay the initial costs of a diviner school. Those who are so isolated that they are unable to rely on support from any family members, usually belong to the Zionist Church as it is a less costly alternative. On the other hand, potential initiates who have closer family ties, rely on their

sense of obligation to honour the wishes of the shades and a persuasive diviner.

In this chapter we have explored a range of illness episodes and social contexts in which natural or non-natural causes have been highlighted. An initial attempt has been made to ascertain the reasons why in certain contexts, explanatory models highlight natural as opposed to non-natural aetiology. We have seen that in instances where therapy has proved unsuccessful or a social situation deteriorates, for example, aetiological explanations can be revised to include non-natural causes. It can be suggested at this stage that social variables appear to closely influence the choice of aetiological decisions.
We shall, however, test Comaroff's (1981) contention concerning the relevance of the social context in aetiological decisions, by holding constant a particular symptom and ascertaining the way in which therapeutic management varies. The relation between illness and its psycho-social context has been emphasized by Comaroff (1981; 1982), Janzen (1978), Morsy (1980), Lewis (1971) and Young (1978), to mention a few illustrative examples. The relationship, however, cannot be held to be valid until it is tested in the form of an hypothesis. It is to this end that Chapter 5 is devoted. The relationship will be shown to have great relevance for the contextual understanding of intwaso which is the essential reason for my undertaking the following analysis.

FOOTNOTE

1. This will be discussed in detail in Chapters 5 and 6.

CHAPTER 5

INTWASO RE-APPROACHED

The object of this chapter is to hone in on 9 illness-episodes in 6 of the 21 households, all of which have members suffering from the poverty disease, tuberculosis. By holding the symptom constant, it is possible to ascertain the extent to which the social context of tuberculosis determines the diagnosis of natural or non-natural aetiology. The form of the hypothesis is as follows:

> "To what extent, if any, is the social context of symptoms the determining factor for the diagnosis of natural versus non-natural aetiology."

Tuberculosis was selected firstly, because the incidence of sufferers in the survey was high. Secondly, because it is a poverty disease with sociological ramifications, the strategy behind the following analysis is to identify the underlying features of the illness intwaso, which in the urban context of Guguletu is linked with tuberculosis in 6 instances within the survey of working class households.

The relation, in these cases, between the symptom tuberculosis and what will be shown to be essentially the explanation of illness and/or misfortune, namely intwaso, is hardly surprising. Tuberculosis occurs in stressful social contexts and so does intwaso. The essential point brought out, however, is that intwaso is either the self-perceived or diagnosed meaning behind the disease tuberculosis, for example, and is therefore not characterizable in terms of any particular series of symptoms. It has also been emphasized that there are many other symptoms of illness-episodes and misfortunes which may be interpreted, post hoc, as being intwaso. At no point is it suggested that TB is either a necessary or a sufficient condition for precipitating the interpretation of a sense of personal chaos as intwaso.

The reason for using TB is that the social dimension can be isolated by holding the symptom constant as a control in ascertaining the extent to which therapeutic actions, notions of taxonomy and illness behaviour are socially determined. In choosing a poverty disease, one realizes at the

outset that the household members are likely to be in need of social healing.

In so doing we will see that the apparently problematic definitions of intwaso are in fact only problematic if it is assumed that intwaso has an absolute group of characteristic symptoms. In fact, symptoms related to any illness-episode, series of cumulatively less "well-handled" illness-episodes or misfortunes are interpreted post hoc by patients, their families and diviners as being caused by ancestral possession. Thus order and meaning are imposed upon a sense of personal dis-ease and the possibility for control, through the help of a diviner network, is made feasible.

Thus the urban contextual approach to the study of intwaso is essential to avoid seeing intwaso in a vacuum and consequently gaining a distorted and limited understanding of the condition. Although the social factors mentioned are strictly tied to the urban problems of a Black township community, they should not be regarded as the only current context for intwaso, nor as unique determining factors. They are mentioned, because to study any phenomenon in a vacuum is counter-productive and likely, as in the case of many studies of intwaso, to result in misconceptions. This is certainly true of the work of Laubscher (1937, 1975) and Kruger (1981), to mention only two of many examples which will be analysed in detail below.

In the following two households, tuberculosis is not considered to have an underlying meaning. In the first instance this is because the sufferer is retarded and incapable of such a perception. In the second it is due to the fact that R's husband is financially supportive and that she has someone to look after the children. It was also possible for her to give up her job in a clothing factory. Under these circumstances R was able to adopt a sick-role and obtain both rest and biomedical treatment. It was therefore unnecessary for her to use the idiom of intwaso to justify her neglect of responsibilities due to sickness.

Household 1 is matrifocal and, as mentioned in Chapter 4, Case 8, is is a great burden to the family to have a retarded son who is economically unproductive. His contraction of tuberculosis is closely linked with dire financial circumstances; ten family members, consisting of seven adults and three children, rely on the earnings of two wage-workers and the daily

payment of irregular "char" work. The basic structure of their house, provided by BAAB, has not been improved in any way. This is unusual, as most Guguletu residents have made some attempt to improve their living standards by adding interleading doors, laying tiled floors and putting in ceilings, to mention some basic examples. The children were without warm clothing and shoes, despite the cold weather. It is suspected that the son suffers greatly in this environment and there is no possibility of his having sheltered employment in the near future. As far as the aetiology of TB is concerned, his mother, who is in charge of therapeutic management, claimed:

> "The TB comes when you do not eat well... we eat very little meat and vegetables."

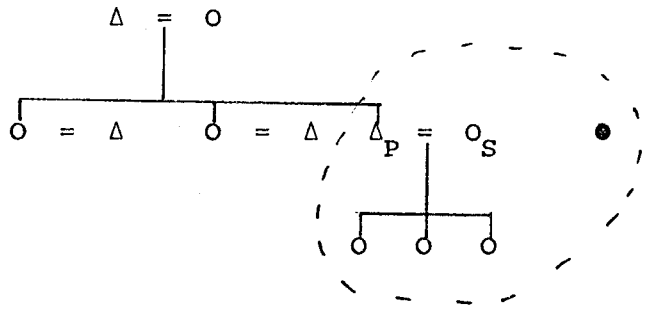
As soon as Peter began to cough blood, his mother and eldest daughter took him to a private doctor in Retreat, whom they knew to have a good reputation. The latter referred him to the TB clinic in the Uluntu centre, which he attends three times a week. Initially, his mother accompanied him but later the routine became so familiar that Peter was able to go by himself.

As far as the family were concerned, the TB clinic had been helping Peter and there was nothing more they could do to help him. They did not believe that anything could be done to relieve the symptoms of retardation. It is clear that naturan and non-natural aetiology were not confused in this eposide. The family, however, dealt with the social effects of poverty, by joining a Zionist Church which provided spiritual healing and to a lesser extent, financial support. This helped to bolster a fatalistic acceptance of their circumstances. Peter motivated no further treatment. As a result of retardation he had no perception of an underlying causal dimension, as might otherwise have been the case in the financially-stressed household-context.

On the other hand, in Case 12 : household 11, there was acceptance, as opposed to resignation, because the social context of illness was stable. R's husband gave her adequate emotional and financial support in time of illness. It was clear that TB was due to inadequate eating habits, as opposed to lack of food. According to R, she frequently "just did not have time to eat", or was "too tired to bother with food after work". In this context, R did not need to rely on members of her manyano group for emotional or financial support, because this need was filled by her

immediate kin.

Case 12 : household 11



R. is 30 years of age and lives with her husband, P, of 45 and her three children of 5, 3 and 2, who are not as yet at school. Her husband has a relatively well-paid job at a liquor outlet, and so at the onset of TB symptoms, R was able to quit her job, because her children are not yet at a stage where they require a great deal of economic outlay. Because of the presence of a female lodger, whom she calls "Aunt" merely as a term of affection, she is able to adopt a sick-role. The lodger is a 55 year old migrant who is unable to find work because of her illegal status.

As far as R.'s notion of aetiology was concerned, she claimed:

> "As soon as I started to feel a pain from my cough, I thought it might be TB, it just comes to people here.."

She was not concerned as to why she had become ill, although she thought it possible that she had "not eaten the correct food because she was too busy working to cook properly". She did not consider going to an igqira with a chest pain, because she thought they would talk nonsense:

> "They just say you have poison, when really it is TB".

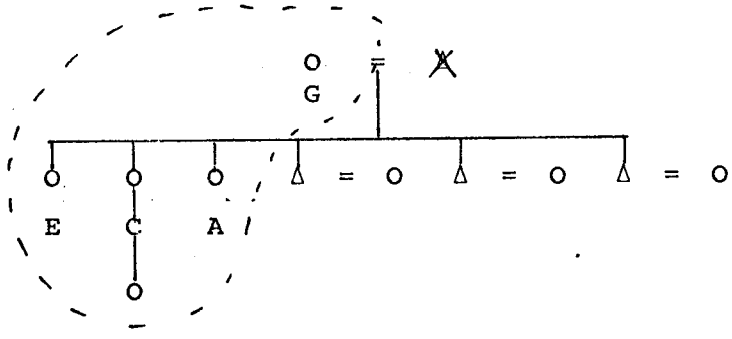
R. was quite satisfied with the diagnosis and treatment of a private doctor, but did not enjoy having to wait for hours each day at the Uluntu clinic. She also belongs to a Manyano group, where they have prayed for her. Laughing wryly, she said she did not have enough faith to be cured by prayer alone.

In this example we see how important the social variable is in determining the nature of the choice in aetiology. Natural causes were highlighted,

because the family considered that the biomedical treatment gave them adequate control over the condition and R did not have to justify her adoption of a sick role in terms of the idiom of ancestral possession.

The financial situation of the following matrifocal household 13, contrasts starkly with the relatively comfortable living standards of household 11. The members of household 13 do not perceive themselves as having any control over the illness, therefore they emphasize non-natural aetiological explanations for the condition.

Case 13 : household 13



In this matrifocal household, TB is attributed not merely to malnourishment, as in Case 12, but also to a disintegration of family ties between the living and the shades. Their extreme poverty was explained by Mrs. G as being due to the neglect to perform ukukhapa for her husband's shade. Instead of "marrying her husband to the ancestral shades" by slaughtering an animal and thus sealing the bond between the recently deceased and his ancestors, Mrs. G. had "only bought some meat from a shop". Despite the fact that she had wished to do more after her husband's death from TB, ten years previously, she was unable to afford the customary requirements. In this way they believed that they had lost the support of the shades. Without their guiding influence, the sons had ceased to care about their mother and sisters, consequently, without their financial assistance, TB was "revisited upon" the 24 year old daughter (A). It was seen to result from the spreading effects of an inharmonious relationship between living family members and their shades.

In fact ever since the father's death, the household had continued to suffer successively worse misfortunes, particularly because all three sons, who no longer lived at home, ceased to give financial assistance to their mother

and sisters. Because of their acute financial situation, it was hardly surprising that another member of the household contracted TB. The household's key source of income is derived from Mrs. G.'s pension, and unreliable payments of maintenance from C.'s boyfriend, for the support of their baby. Although C. had reached standard 7, unlike her mother and sisters who had not continued schooling beyond standard 4, she was unable to find employment. Another source of income were the wages paid to the eldest daughter, E, who was a domestic worker. Mrs. G., who had been employed as a domestic worker ever since she had left the Ciskei, retired at the age of 60. According to Mrs. G., her husband had died of TB because they were unable to afford regular meals and that malnutrition was also partly her daughter's problem. This natural aetiological explanation was not, however, emphasized because it was perceived that there were also underlying reasons for their misfortunes. Thus we begin to see a trend, namely that the non-natural explanation for illness is highlighted in certain circumstances where social healing is perceived to be necessary. In this instance it was used to explain the breakdown in family ties which caused the precarious financial situation in their household unit to deteriorate.

When the 24 year old daughter, A., began to exhibit the symptoms of a tight chest, coughing and vomiting blood, the family immediately diagnosed TB and she went to Guguletu Day Hospital at the family's insistence. She was referred to the TB clinic for treatment which, although minimal in cost, was nevertheless an extra burden. When asked if she was satisfied with the treatment, she told me:

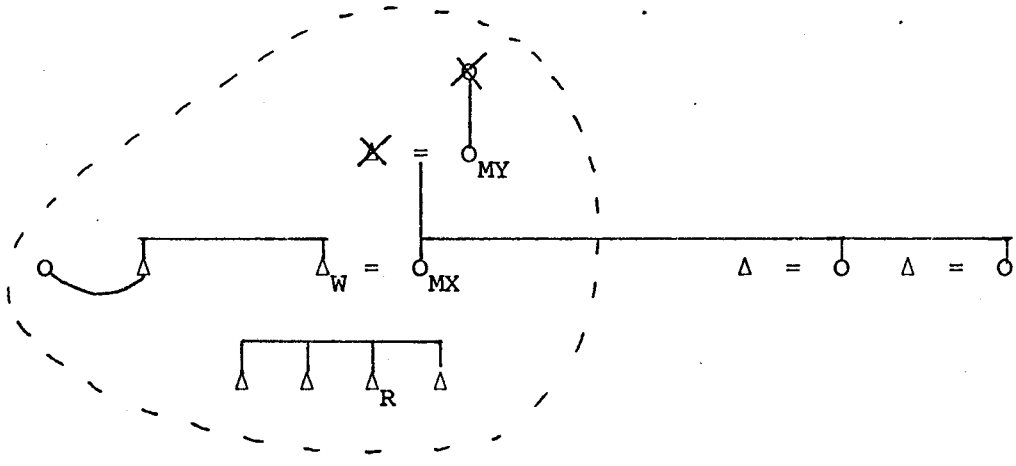
> "If you are not satisfied it is too bad. We cannot talk back, we just sit and pay, that's all... They take no notice if you complain... it is the only place for me to go.."

In order to ask forgiveness of both the shades, and of God, the family attended Zionist healing ceremonies, which they hoped would "take away the bad things" from their household. They explained that although the amagqira could also help their situation, they preferred to go to the Zionists for help as they were less expensive. This choice is supported, for example, by Kiernan's research (1977 : 31) in which he makes an attempt to understand the Zionist religious movement "in relation to conditions of poverty and to the social depression which is their inevitable concomitant", as will be discussed below.

In this isolated family there were no extended family members upon whose support the family could prevail to help them perform ukukhapa, nor were there any members prepared, or able to help them meet their day-to-day living requirements. Under these circumstances, Zionist healing was considered by Mrs. G. as a more viable option than the amagqira who are mutually supportive and require an initial financial outlay.

In Case 14 : household 14, the spreading effects of the death of her husband from TB, her loss of economic independence, emotional support and her grandson's contraction of TB, made M.X.'s mother, M.Y., perceive that she was intwaso. She had lived in turn with all her daughters, since she had been widowed, but claimed that she "felt it was right to live in M.X.'s house as it had originally been her own home". Thus she legitimated her choice of residence.

Case 14 : household 14



The household consists of four children and five adults, three of whom are employed. Mrs. M.X.'s husband, W., who was born in the Ciskei and is "trying to qualify" for residential status, works at the same construction company at which his brother is employed. His brother's girlfriend is illegally in Cape Town and is therefore unable to find work. No one in the family has been educated beyond standard 4 and all are unable to find anything but semi-skilled or unskilled jobs. Mrs. M.X., for example, works for a few hours every morning at a primary school in Guguletu, making soup, for which she is paid R27 per month. Despite the smallness of this sum, it is worth her while as it helps to "stretch the family budget".

Because Mrs. M.X. and her husband have four children under the age of 12 years and under to support, she admitted that although "they managed", they

were unable to eat a balanced diet or afford anything but the most basic living requirements. During the winter all her children had had coughs and colds, and were taken to the Guguletu Day Hospital. Her 9 year old som, R, however, seemed to have a worse cough than the others, and so Mrs. M.X. decided to take him to the Red Cross Children's Hospital in order to be sure of prompt treatment. He was diagnosed to be suffering from TB and was referred to Guguletu TB clinic which he attended, accompanied by his mother, at least three times per week.

In order to cope with their anxiety, poverty and illness, all the household members were staunch Zionists. The grandmother, however had dual membership with St. John's Anglican Church, This spiritually supportive network, however, had not prevented her from feeling that she was intwaso. She had been wearing white beads for a month before the time of our meeting, in order to ward off the possession state, which she believed was "coming on". Usually beads are donned by initiates once the ceremony of invuma ukupha (the acceptance of the illness)(1) has been performed. This was an unusual prophylactic measure as she claimed that she would not become an initiate: "It is a heavy thing and takes time". She expressed the hope that the beads would protect her from the sharp, stabbing pain in her stomach, a symptom called umbilini ihlaba, which is associated with the ancestral calling, intwaso. She considered that the symptoms had been sent by her mother's shade. They were perceived to be extremely compelling as her mother had been a diviner.

The grandmother's inability, as an old woman, to be anything but a further economic burden lead her to perceive that the family troubles and her own ailments were part of a calling. It is necessary at this point to mention in passing that it is possible that intwaso, which occurs coincidentally with misfortune and illness-episodes may in some instances have a genetic component: conditions such as physical deformities and epilepsy, for instance, are interpreted post hoc and explained as being part of an ancestral calling. It is also possible, however, that the possession states are presented through socialization as a way in which to cope in similar stressful situations. It is not, however, suggested that genetic predisposition is either a necessary or a sufficient condition for intwaso. This contention is not shared by researchers who study the condition in a social vacuum and suggest that schizophrenia and intwaso have strong similarities. This contention will be discussed and criticized in detail below.

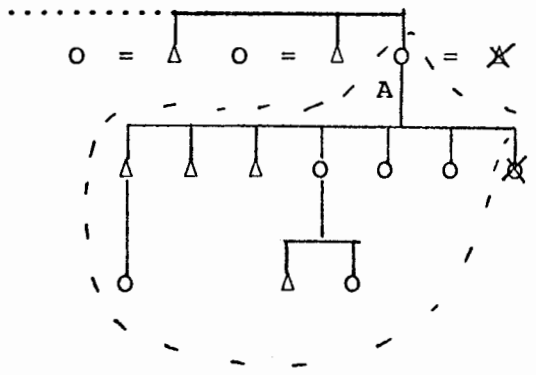
Mrs. M.X.'s mother avoided following the calling, because she was unable to pay a diviner's apprenticeship fee, nor could she afford a goat or a cow. Wearing the white beads, however, made it clear to everyone that she was vulnerable and in need of respect and special attention.

In Case 14, as in others mentioned in this chapter, we can see that illness is not considered to be an individual problem, but rather the problem of the household members, because it has spreading effects. In this household, perceived misfortune and a sense of anxiety resulting from two of the family members' contraction of the poverty disease, TB, was controlled by wearing beads in order to appease and bar the calling of the shades.

Thus is can be seen that in each of the above households, notions of aetiology and therapaeutic management have differed due to the varying social contexts of the control-symptom, tuberculosis. We have also seen that ancestral calling is the perceived meaning behind a family's misfortunes and illness-episodes. This argument will be expanded and demonstrated by the analysis of the illness-episodes of the following two households.

Case 15 : household 16 is headed by Annette, (A), aged 44, who was born in the Tsomo district of the Ciskei. She came to Cape Town in order to seek domestic work where she met and married her husband. Together they lived in Simon's Town until they were moved by the Council to Guguletu in 1966. Their life together was interrupted in 1979, when the husband and the eldest daughter died of TB, within months of each other.

Case 15 : household 16



The father died first as he had not obtained treatment sufficiently early. When the daughter, not long after his death, began to complain of a painful

chest, it was immediately suspected as being TB. Annette sent her to Mrs. A.D., an igqira who lives two doors away to find out why the whole family was suffering misfortune. According to Mrs. A.D., the mother had received no schooling in the Ciskei and did not understand the problem. She told the daughter that she needed nursing first and referred her to Groote Schuur Hospital where she was treated. Treatment unfortunately came too late and she died within the week. Immediately after this double loss, the mother returned to her brothers in Tsomo to offer a cow for her husband and daughter, in order that their shades might be incorporated with those of their lineage. According to Mrs. A.D., who is both a friend and neighbour:

> "By the time she left the "Blue-line" bus (which transported her to the Ciskei), she did not know what she was doing and her brothers found her wandering in the bush, days later."

Since that time she has been very depressed and speaks rarely. According to Mrs. A.D.:

> "Before these deaths she was a different person."

Zionist prayer meetings were frequently held at their home to ensure that the ancestors were "under the pillow". Because of financial reasons, they relied mostly upon Zionist support, although Annette also claimed that an igqira would be able to help them just as well as the Zionists, because she saw their underlying problem as being one of ancestral neglect.

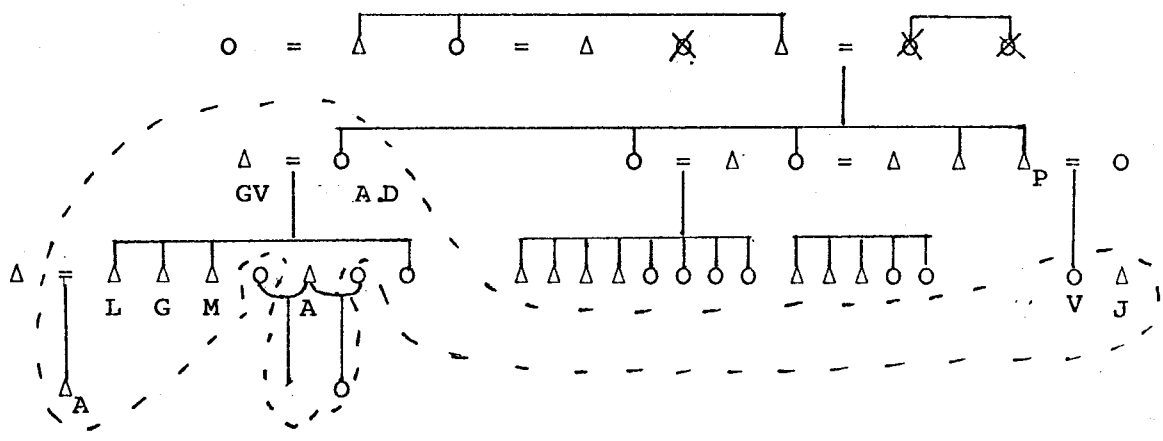
In this example we see the spreading effects of an emotional loss, dealt with by Zionist spiritual healing, because the family were unable to afford the cost of diviners. We also see that Annette's explanatory model has since expanded to include a natural causal dimension of tuberculosis. All her children are regularly taken or sent, depending on their age and degree of independence, to Guguletu Day Hospital, whenever they have severe coughs. Prophylactic measures used by the family were concentrated at the spiritual level, while the children, due to their financial situation, were poorly nourished.

The ten members of the household relied entirely upon the earnings of two sons who work at a factory in Simon's Town, and the irregular wages of a daughter who "chared". The mother herself, did not work because of her depressed emotional state. The 12 year old son was at school and the 5 year

old was going to start school the following year. The 15 year old daughter had long since left school to search for employment, but was unsuccessful. As a household, not one had passed beyond standard 4.

In this household, as in households 1, 11 and 14, the adults have a number of dependants who are economically unproductive. Tuberculosis, therefore coincides with periods in the family's developmental cycle when few members of the household are economically productive, because they are either too old or too young. In household 20, tuberculosis also occurred at a time when the number of dependants exceeded the supportive ability of the breadwinners. It is also presented as an example of a social context in which the aetiology of TB was perceived to have underlying causes with wide-ranging effects.

Case 9 : household 20



Mrs. A.D.'s extended family was wide-ranging and the members of her household, represented by the encircled area of the kinship diagram, potentially encompass both agnates and affines, some of whom have come to stay at various times over the years. This is important as the household, although apparently static in the above diagram, fluctuates as the members of the extended family come and go. The reason why this has been emphasized is that the size of the household and the number of people who are economically productive is directly relevant to a household budget and determines, partially, their standard of living and health. As emphasized in Chapter, 4, however, there are other even more important factors beyond the micro-level of the domestic unit which contribute to the breakdown of health. In other words, finances might also be at a low ebb due to the structural forces beyond householder's control, such as lack of bargaining power, retrenchment, and the effect

of the Coloured Labour Preference Policy, to mention a few examples.

This particular household has had great fluctuations in its standard of living over the years, due to some of the above-mentioned factors. They are resigned to the fact that jobs are hard to find and that, once found, they may be lost without warning. They were also only too aware that unless as many of them as possible were working, it would be difficult to make ends meet. Within the past two years since I have known them, Mrs. A.D.'s son, A, for example, has had four jobs, for one of which he received no wages as he was to be paid on a commission basis. Mrs. A.D.'s husband has lost his job twice: first as a night-watchman, after which he was without work for six months. In June 1982 he, along with A and V's husband, were retrenched from Koeberg. Retrenchment from one company resulted in three members of the same household being without work. The temptation to traffic in marijuana was considered by A under these stressful circumstances. He did not, however, continue with this scheme, as his mother begged him not to be irresponsible. L, a matriculant nurse-aide and her brother, G, who worked at a beer hall "and drinks his pay", according to Mrs. A.D., were mainly responsible for supporting the household members. The youngest son, nicknamed "Butterbean", also helped as he has a cleaning job at Guguletu Day Hospital, while Mrs. A.D. charred once a week. Mrs. A.D., however, also belonged to an umgalelo (savings club)and had extensive networks of fellow diviners, initiates and also Zionists, who are mutually supportive.

Although Mrs. A.D. is married and lives with her husband, she is very definately the household head. Soon after a marriage into which she had entered resentfully, she gained a measure of independence by becoming a diviner. Despite the additional income earned by her in this way, the standard of living plummeted when members of their extended family who are not economically independent were included in the household. In the 1960's this situation occurred, and Mrs. A.D.'s husband G.U., contracted tuberculosis. His condition deteriorated so rapidly that he was hospitalized at Westlake Sanatorium. Mrs. A.D. interprets her nuclear family's problems of severe illness and lack of work as being caused by the shades "turning their backs upon them".

At the time, E, Mrs. A.D.'s sister, who had also contracted TB, was living with them. She had been deserted by her husband who left her with seven

children to support. Before going to live with her sister, E had also suffered the anxiety of trying to cope alone with a son who had been institutionalized at Valkenburg, because of his violent behaviour. Under these circumstances her contracting TB was seen as the last straw in a cumulative series of misfortunes which were interpreted as being due to itwaso.

After E had received treatment for tuberculosis, she decided to pursue her ancestral calling for fear that she would become mad if she did not. Tuberculosis was perceived to be the final trouble (inkathazo) in a long series, which she dared not ignore. Thus everything that had troubled her was put into a new controllable perspective. The perceived intwaso also enabled her to adopt a patient-role. In this way she was able to justify going to the Orange Free State and leaving her children in the care of her sisters, so that she could apprentice herself to the diviner, of whom she had dreamed.

E's tuberculosis symptoms were thus interpreted as being part of the calling. Mrs. A.D. interpreted her husband's similar TB symptoms to be the result of ancestral displeasure, because their relationship with the ancestors was considered "not right". Both E and G.U. underwent biomedical treatment: however, the social dimension was in both cases viewed to be important and received treatment which they believed to be beneficial. Thus in these two episodes, the physical and social levels of illness were treated not simultaneously, but sequentially.

According to Janzen:

> "they foreshorten causal changes of events, selecting the cause that is socially relevant and neglecting the rest. Witchcraft (for example) is frequently selected out of a number of co-operating causes because it is the ideological pivot around which swings lengthy social procedures..... to attribute misfortune to witchcraft (or ancestral calling, or ancestral neglect) does not exclude the real cause, it is merely superimposed on them and gives social events their moral value."
>
> (1981 : 188).

It is important to emphasize that although the "socially relevant" cause may be highlighted, the other causes are not neglected, as the fieldwork data clearly indicates. In fact, in the case of TB, the symptoms are nearly always treated biomedially, whereas the social aspect may be treated

either by the Zionists or by the amagqira, depending on preference or a financial position which excludes the use of an igqira. In instances where the social context is not considered stressful, the underlying causes of the illness are not highlighted. This is also the case in instances where the sufferer is retarded or for some other reason does not take an active interest in the treatment of their illness.

Now that a discussion of intwaso has been motivated via an analysis of the urban context of therapeutic-management-decisions, relating to one symptom, namely TB, the way in which my definition and understanding differs from that of other approaches, will be determined.

It has been mentioned in Chapter 1 that Hunter (1935), Soul (1974), Gitywa (1963) and Laubscher (1937, 1975) for example, held to a greater or lesser extent that a definition of the "illness-category" intwaso was problematic, because of its lack of a definitive range of characteristics. Hunter, in particular, states this explicitly, and it is to her credit that she does not gloss over the problem as did the other researchers. An attempt will be made to show, via an analysis of the household cases that the assumption that intwaso is an illness category, as opposed to the perceived underlying meaning of illness, often leads to such misconceptions.

Intwaso is not a descriptive level for a group of characteristic symptoms, if it were, diagnosis would be consistent, or nearly so, for all the episodes and a situation such as that revealed by my analysis of TB symptoms, could not have arisen. Nor can it be said that intwaso is merely a category of experience, as argued by Schweitzer (1977, 1978), who uses it to imply a definite range of conditions. To quote an astute informant:

> "Intwaso comes in different ways to people, sometimes in a clear way, sometimes not."

As such intwaso can be self-perceived or applied by either the individual, his family or the diviner to a wide range of illness conditions or misfortunes. It will be argued that intwaso cannot be equated with the condition schizophrenia, as did Laubscher (ibid), nor should the assumption of an exact parallel between intwaso and schizophrenia be the basis for research, as in the case of Kruger's (1982) recent project. Both Laubscher and Kruger are comparing two phenomena of a somewhat different order, namely a perceived

explanation of illness or misfortune on the one hand, and the diagnostic lable schizophrenia (which is in itself problematic), on the other. The biomedical perspective towards schizophrenia, however, is by no means uniform. It could for instance be argued by members of the Humanistic Existentialist School (2), such as Szasz (1975) and Mechanic (1974), for example, that schizophrenia is similar to intwaso in that it is also a post hoc interpretation place upon a series of events by a psychiatrist. Even if schizophrenia is not merely regarded as a diagnostic lable with a poor prognosis and is seen to be a process of growth and development, it is, however, not of the same order as intwaso. One of the major differences is that intwaso is a far more flexible explanation for a wide range of unfavourable life experiences. In some instances intwaso is only self-perceived and does not receive the sufferer "shops around" for a healer who agrees with their self-diagnosis and legitimates their initiation into a diviner school. The choice is wide and may in some cases include both biomedical and indigenous healers.

It can also be argued that, although both schizophrenia and intwaso are arbitrary, intwaso is not only the explanation behind various symptoms and misfortunes, but is also perceived to be a gift given by the shades to their chosen protege. Although intwaso initially involves physical or emotional suffering, it also enables those who successfully follow the path of intwaso to become healers of others. Not all diviner's novitiates progress beyond the initial stages. In these instances, the diagnosis is often altered and they are referred to biomedical healers.

Intwaso is used by initiates for many reasons. For instance, to gain freedom from responsibilities and access to a mutually supportive network in which they learn to become capable and socially resourceful. In some cases it is used to fulfil a desire to attain a new, powerful status in a diviner-community (See Chapter 6). The strategy of leading one's family and psychiatrist to believe that one is schizophrenic might be useful in adopting a patient role resulting in institutionalization and a freedom from responsibility. Although the process of exploiting the sick-role may be similar in many respects for both conditions, the end result is considerably different. Initiates gain not only a sense of prestige and independence, but also become powerful members of the community. On the other hand, inmates become stigmatized and dependant. It is therefore conceded that

although there may be an overlap in some respects between the two conditions, the relation between them is not exact.

I shall approach an analysis of Laubscher's work on intwaso by analysing some of his arguments. In the main, Laubscher's work emphasizes the cultural aspect of intwaso and its similarities with schizophrenia. In so doing, he looks at intwaso, purely at a psychological and so-called "cultural level" without grounding and situating the condition within the societal or structural context. For example:

> "The native's conception of mental abnormalities and of the scope and range of behaviour which he allots to normal individuals, is bound up with his surrounding environment and coloured by those customs and beliefs underlying witch-craft and ukuthwasa. The cultural heritage of the native determines his perceptions, according to mythological beliefs, and determines in the main, the nature of his de-lusional content."

This statement seems to indicate that Laubscher equates delusions with cultural content. He thus regards abnormality in an absolute sense as seen by Cowcroft (1967) and Deveau (1978), for example, rather than in a relativist sense. He uses his own emic cultural views and biomedical bias to interpret the informant's viewpoint. From this premise, he argues:

> "Hence mental disorder is accounted for by the causative factors of belief and these causative factors are not ascribed to disruptive influences in the personality, but to exogenous causes, belonging to the domain of mythology... (ibid).

This is an oversimplification of African medical cosmology, which even forty years ago when Laubscher's research was conducted, had demonstrated a notion of personal and impersonal dimensions of causation. For example, Evans Pritchard's study (1936) of the remote Azande, showed that there was an interplay between natural and non-natural causation.

He equates delusional content with their mythology, for instance:

> "The cultural heritage of the native determines his perceptions, according to mythological beliefs" (ibid).

In so doing, he shows that he considers abnormality to be tied to primitive beliefs, an ethnocentric and unfounded statement.

Laubscher continues in the same vein, emphasizing only the personal dimension of cosmology:

> "The native recognizes mental abnormality but will not accept it as a disease of the mind having its origin in the mind or in the constitution of the individual. It is caused by some extraneous factor over which man can exercise control, if the proper man and the proper medicines are employed in the treatment."
>
> (1937 : 221).

This is clearly untrue of the urban population of Guguletu, as illustrated by the above examples. At the risk of being repetitive, I shall quote yet another two paragraphs in order to summarize Laubscher's contentious argument:

> "The description given of the type of person who is called to the River or his condition during ukuthwasa, just prior to calling, portrays fairly accurately a catatonic phase or depressive phase in a schizophrenic or manic depressive or epileptic psychosis. It is not uncommon, if one goes into detail of the mental content of native schizophrenic patients, to elicit from them that they were ukuthwasa and heard the call of the ancestors or the River people, but were prevented from undergoing the training of an isanuse (3) by the other people."
>
> (1937 : 5).

This is also a problematic argument, particularly because of his assumption of the nature of intwaso and because he denies that the River people and ancestors may, in fact, be used to fulfil rational functions such as symbolizing marginality, distinctiveness, disorder, awesomeness and power, in the sense used by Douglas (1966, 1967 and 1070). It will be argued in the following chapter, that they might be used to extend one's supportive network in legitimating what is perceived by the sufferer as the need to adopt a patient role, and in so doing, also motivating recognition on the part of his family and chosen igqira. The latter in turn gives one access to a wide supportive network of fellow initiates and diviners (see Chapter 6).

Laubscher also over-generalizes in suggesting that all people are called to become diviners because they are mentally imbalanced. He is, in fact, forced by his fieldwork to slightly contradict this dogmatic generalization, for instance:

> "The ukuthwasa is the period of psychic abnormality which a person must experience before the full development of mediumistic powers. To become an isanuse one must pass

> through a period of abnormality. A girl whom I personally examined during a period of ukuthwasa, revealed no evidence of psychosis, but rather a heightened emotional sensitivity and instability."
>
> (1937 : 31, my emphasis)

Ngubane at a first reading appears to argue from a stance quite close to that of Laubscher's, for instance:

> "I see the notions of alien spirit possession are closely related to the extreme form of depression or nervous breakdown, which may be coupled with hysteria and suicidal tendencies."
>
> (1975 : 56).

Her stance does, however, differ in that she distinguishes between types of indigenous possession which will be discussed below, so that the quotation is applicable only to alien spirits such as amafufunyana and indiki, not to lineage-shades. Ngubane (1981) expands on her understanding of the latter, which are usually deemed to have their descendants' interests at heart, in a recent article by saying that the possession state, intwaso, gives access to amagqira-networks which are important in "maintaining a meaningful world view". In other words, the desires of the shades, interpreted by diviners, give coherence and a sense of direction to those troubled by illness, misfortune and a sense of personal chaos. (This will be discussed in Chapter 6).

Schweitzer (1977), Gitywa (1963 '10) and Hunter, for example, to a greater or lesser extent, make problematic generalizations concerning intwaso, for example:

> "It is also noticeable that most novices being initiated are nervous, hysterical people."
>
> (1935 : 320).

These psychologically-orientated definitions rule out the possibility that people in some social contexts may use possession to strategize and legitimate their adoption of a sick role by their entry into wide-ranging, powerful amagqira networks. Not only the weak use intwaso to gain passive-mastery over the strong, in fact many wilful men and women, as will be indicated in Chapter 6, perceive themselves intwaso, as a way in which to change their role or situation in life. It will be argued that it is not in fact used only be "the halt, the lame and the blind" in the physiological or psychological sense.

Kruger (1980), like Laubscher, assumes that intwaso and schizophrenia are synonymous. This is possibly because, being a psychologist, he has not rooted his research in broader social contexts and has concentrated instead on what he sees to be the phenomenon in itself. He writes of intwaso as follows:

> "Reformulated phenomenologically, it means that a structure of the world is announcing itself into his self-system. This sort of experience is labelled as an acute schizophrenic-episode".
>
> (1981 : 56).

The same criticisms directed at Laubscher's work can be directed at Kruger's, as he oversimplified the range of symptoms which may be perceived by sufferers themselves, as a call from their shades, and labelled them all "schizophrenic". O'Connell (1982) is correct in criticizing Hunter's (1935 : 320) contention that women are more inclined to hysterical behaviour than men, or that intwaso is a kind of "functional nervous disorder". In criticizing Hunter, however, he errs in taking the opposite stance, which is equally unrepresentative, for example:

> "Intwaso does not involve hysterical behaviour in all instances and diviners, in general, do not behave hysterically when they are at home and not at a public seance."
>
> (1982 : 28).

In fact, in some instances, the initiates may be suffering from a functional disorder. In criticizing Laubscher (1937), I did not rule out the possibility that some functional disorders may also be diagnosed or self-interpreted as being the result of ancestral calling. What I am saying, however, is that although in some instances it may be a sufficient condition for intwaso, it is not a necessary one. I have witnessed great anxiety, posturing and hysteria, for example, amongst initiates in the early stages of the process of intwaso, when the sufferers have not as yet "found a controlled form for their sickness" (Janzen, 1982, pers. com.) or a way of accommodating perceived misfortune within an ordered meaning-framework. As the initiates progress, they learn to control their anxiety more successfully while somatized anxiety such as headaches, stomach-aches, dizziness and rapid heartbeat also disappear or improve. It is necessary to emphasize at this point that some initiates never reach the stage of intwaso when they are able to become a qualified diviner. This occurs for many reasons: some decide that they would prefer not to go further, others are

unable to afford a further sacrifice to mark their progress to the next phase, while a number suffer from physical or psychotic conditions which are so extreme that they prevent them from continuing. Under the latter circumstances, the igqira who originally made the diagnosis revises it.

Often his or her fellow-amagqira point out the mis-diagnosis by saying "the beads are not right for the umkhwetha's sickness."

O'Connell claims that intwaso has been associated with marginal, subordinate and under-privileged persons. He also claims that case-histories indicate that intwaso can occur when an individual experiences failure in role performance (1982 :36). He concludes:

> "The increase in the number of diviners may be linked in part with an increase in population, but there appears to be a relationship between intwaso and the stress associated with contact with white South Africa, in other words, with external stress."
>
> (ibid).

This condition is problematic on three counts. Firstly, intwaso occurred in pre-colonial times, something which he did not make clear in his paper, which is ahistorical. We had no exact record as to how numerous diviners were, although from ethnographic records it is apparent that they were an important aspect of African life. The incidence of intwaso cannot therefore be described as being linked directly with so-called contact with white South Africa as it is not a new phenomenon. Secondly, "Blacks" and "Whites" are privileged members, by virtue of South African classificatory laws and a host of "protective" statutes. If, therefore, "Blacks" are subject to stress, it is due to their position in the South African social structure, not merely contact with White South Africa which exerts an "external stress". Most "Blacks" live or work in South Africa and if they live in the"homelands", their economic welfare is shaped by South Africa, on whom they depend. As such the homelands are not pre-capatalist but continuous with the South African capitalist economy. Because of the clarity and conciseness of Spiegel's argument, I cannot do better than to quote him:

> ".... there are inevitably technical inputs from 'outside' which support so-called 'pre-capitalist' relations in remnant 'traditional' societies. Thus items like implements, seed, etc. are imported to allow for cash crop productions in many places where so-called peasant producers work the land. The argument is that one cannot talk of a persistence of a pre- or non CMP (in articulation with the dominant CMP) if, at

> the level of factors of production, inputs from the CMP are required for the production of the non CMP sector. The argument becomes that much more forceful if the means of reproducing the apparently non-capitalist sector derive from the sale of wage labour to capital....."
>
> (Spiegel, 1980 : 160)

Thirdly, failure in role performance due to stress is once again a sufficient condition, but not a necessary one for perceiving oneself or being diagnosed intwaso. Intwaso is the underlying meaning given to a series of less well handled symptoms and misfortunes which may, or may not lead to role failure, depending on their severity. Intwaso has been reviewed negatively, whereas in fact in some instances it appears to have a positive, adaptive function such as manipulating the patient-role, in order to gain passive-mastery (Turner, 1968 : 154) over one's environment. In this way people avoid having their desires thwarted.

Thus intwaso should be studied within a social context in order to understand both the nature of the condition and the behaviour associated with it, as opposed to merely psychological speculation about the symptoms which are seen as isolated from other illness-episodes.

Fourthly, to take up O'Connell's artument concerning role fulfilment from another tack, intwaso existed during pre-colonial times and was possibly attributable to the stresses of "traditional" patrilineal social structure, not merely to poor role fulfilment related to the stressful nature of South African society. The position of women in male-dominated families may in some instances still be a contributory factor in urban townships, as ethnographic data on amagqira suggests.

According to Hunter (1935 : 320):

> "More women ukuthwasa than men, of 26 amagqira I knew, 21 were women and I had as much opportunity of hearing of men amagqira as of women... many women amagqira ukuthwasa about menopause..."

This contention has been widely supported by Bryant (1917), Hammond Tooke (1962), Krige (1936), Gitya (1963), Ngubane (1975 and 1977). In Chapter 4, Case 10 : household 3, is an illustrative example of V.'s ancestral call which supports this contention.

Bryant (1917), Hunter (1935) and O'Connell (1982), to mention a few, claim that intwaso is largely confined to married women. Once again, this appears to be an over-generalization. In the urban township Guguletu, I have seen young boys of 12, unmarried girls of 15 and men both married and unmarried, undergoing the process of initiation. Female conditions such as menstruation, pregnancy and menopause do result in perceived stress in certain social contexts, which may possibly contribute to the perception of intwaso as being the meaning behind female symptoms, but it is certainly not limited to them.

Ngubane (1975) has attributed the higher incidence of intwaso in women to female marginality. O'Connell wrongly criticizes her by stating that the marginality argument does not explain intwaso amongst men. In fact, Ngubane (Sibisi) makes it clear that:

> "Divination is a woman's thing, if a man becomes possessed, he becomes a transvestite, as he is playing the role of a daughter rather than a son (in relation to the izinyanya). The special and very close contact with the spirits is reserved for women only. Women are marginal and can thus fulfil the important social role of forming a bridge between the two worlds."
>
> (1975 : 50).

Her rendering of transvestite, however, only applies to a man's role as diviner, which according to informants such as Mr. C.G., requires a man "to be like a woman with his initiates." Mr. "Golden" M. symbolizes his womanhood, for example, by wearing an apron over his diviner costume when he attends iinthlombe.

A final criticism which must be levelled at Laubscher's (1937), Kruger's (1980), and, to a lesser extent, Schweitzer's (1977) work, is that not only did they neglect to situate their analysis of intwaso within a broad range of general illness-episodes to provide a context or control, but they also did not attempt to situate intwaso as a category (to use Schweitzer's terminology), within a range of informants' emic "categories", which are by no means discrete, as Schweitzer implied in his discussion of intwaso, amafufunyana and phambana. Laubscher claims that initiates may be possessed either by the powerful, wise River people who live beneath the surface of the water in much the same way as the cattle herding AmaXhosa or by the shades. He does not mention any of the other indigenous categories of possession. Ngubane (1975) makes it clear that there are various types

of emic possession: "amafufunyana, ukuthwasa and indiki", The shades are benign and do not actively punish, although they may "turn their backs" upon their descendents so that they suffer misfortune or illness, if they are neglected (Mbiti, 1969; Ngubane, 1975 and Hammond Tooke, 1975). There is, however, an indirect level of connivance in that the shades allow misfortune to be caused by other agents. Nevertheless Kruger (1980) incorrectly describes the ancestors as punishing descendants. The evil agents are believed to be amafufunyana or indiki, for example, which enter the body of the sufferer causing suffering. Unless the victim receives treatment and asks his ancestors for forgiveness, so that they will once again be protective, he is believed to become phambana (mad). The amafufunyana and indiki are believed to be outside the lineage and do not feel any responsibility for the illness they cause. In the case of intwaso, the maternal ancestors are usually, but not always, believed to be primarily responsible for the symptoms suffered by their descendants. These symptoms are believed to be symbolic of a diviner's call. In the following chapter possession as an idiom for legitimating certain courses of action, will be discussed.

Thus it is clear that intwaso which does not come from evil spiritual influences is usually responsive to treatment and rarely results in madness provided the call is answered. On the other hand, amafufunyana and indiki are explanations given more frequently for untreatable forms of possession, and as such, are often later accepted as being the cause of mental instability when treatment is unsuccessful.

Diagnoses are frequntly revised during the course of illness, for example: a young boy of 16 was believed to be "truly intwaso" at first, but later when his condition seemed to deteriorate, he was re-diagnosed as suffering amafufunyana and advised to go to a mental hospital by another diviner within his network.

It has been emphasized throughout the discussion of therapeutic-management at the popular level that the diviners are but one choice within the therapeutic repertoire of informants. We also became aware that amagqira were used selectively, depending on the perceived aetiology of illness and that only in instances where the residents of Guguletu perceived the symptoms to have an underlying dimension, did they consider the igqira option.

It has been demonstrated that only by studying intwaso contextually, can one begin to understand this possession state.

FOOTNOTES

1. See glossary for a more complete definition and discussion.

2. Humanistic Existentialism arose in reaction to the determinism of psycho-dynamic and behavioural theory and in response to the spiritual problems of the twentieth century. Although sufficiently similar to be united under a single perspective, humanistic and existentialist psychology differ in that humanists place greater emphasis on the individual as an isolated unit and on the satisfaction of needs. The existentialists, however, focus on the individual's relationship to the society as a whole and on the question of his responsibility.

3. A powerful diviner.

CHAPTER 6

THE FOLK ARENA: THE FUNCTIONING OF A CELL OF VERTICALLY AND LATERALLY-LINKED AMAGQIRA NETWORKS.

> "He had tied a bit of worsted round his neck - why? Where did he get it? Was it a badge - an ornament - a propitiatory act? Was there any idea at all connected with it? It looked startling around his black neck, this bit of white thread from across the seas."
>
> (Conrad, 1974 : 67).

The fluid repertoire of therapeutic options used by residents has been studied contextually. Thus we have avoided the "systematic", "monistic" trend of studying "tight little, right little, medical systems" (Last, 1981). We have seen in the previous chapters that in social contexts which are stressful, illness-episodes or misfortunes may be interpreted as having an underlying meaning. Households have been used to portray the social milieu within which therapeutic management occurs, while it has also been emphasized that external, structural factors have a direct and significant influence on the quality of health.

The amagqira healing option is selectively used, either simultaneously or sequentially, with a range of other biomedical treatments or support systems, for many types of illness conditions. Multiple options are regarded by patients, themselves, as being part of a single repertoire, not as competing, discontinuous medical systems. The general discussion of therapeutic management provides the background against which amagqira networks will be studied.

It will be shown that the idiom of ancestral possession is used to both express and give form, to a sense of personal chaos in an individual's life. It has been argued by Park (1967 : 234), Beattie (1967 : 230-1) and Evans Pritchard (1936) that divination itself provides cathartic release. Beattie, for example, says of a person that:

> "...through the ritual performance which divination entails, he is also giving overt expression to his doubts, suspicions and fears. And this at least in some measure is an end in itself"
>
> (ibid).

Park's approach (ibid) is, however, more sociological:

> "Divination has as its regular consequence the elimination of an important source of disorder in social relationships".

It is argued in this chapter that divination and ritual alone do not mediate the conflicts which are explained in terms of perceived intwaso. More importantly the idiom of possession allows for the setting aside of an aspirant's previous role with its attendant identity, and initiation into a warm, caring, mutually supportive group. Although the community is perceived by initiates to be ritually separate from the outside world, one cannot describe it as being liminal in the analytical sense used by Van Gennep (1960): a diviner-community is shaped in direct response to the structural stresses of township life.

Ideally within the diviner-school-community, a sense of communitas is engendered. Community is used in the sense of Tonnies' conception which distinguishes community from the wider social structure of society:

> "All intimate, private and exclusive living together is understood as Gemeinschaft, community Gesselschaft (society) is public life - it is the world itself."

So-called urban diviner communities cannot, however, be sharply defined by the observer as they form broad, overlapping networks which are continuous with other supportive associations. "Communitas" as used by Turner, is an anti-structural bond created in a community of individuals united by bonds specific to their community. According to him, communitas is undifferentiated, egalitarian, direct, non-rational (though not irrational) (Turner, 1974 : 46). The norm of warm, egalitarianism is, however, not always followed: diviners on occasion are extremely unhelpful towards potential initiates and novices can be uncooperative. In general, it can be said that at times the hierarchy which corresponds to the four stages of intwaso causes disagreement within a diviner school. As soon as an initiate becomes dissatisfied with the treatment of a diviner, however, they leave and seek satisfactory help elsewhere, as will be discussed below.

The initial stage of intwaso coincides with various problems. It has been demonstrated that in some instances, intwaso is a way of explaining and coping with perceived illness within the context of untenable social situations.

These include being divorced or left to look after children alone, lack of extended family ties so that there is no one to help in times of trouble, being unable to support a family, friction between family members, inability to adopt a sick-role because of the fear of job loss, suffering from severe debilitating disease such as tuberculosis, without sufficient emotional and financial support, or anxiety over the welfare of family members. In many instances it is also used for positive reasons, for instance to enable one to adopt a powerful position and to mobilise a wide-ranging and supportive network. In other words, it enables those who explain their problems in terms of ancestral possession to give expression and form to their perceived problems and to learn through initiation to become socially effective (Frankel, 1981), or in other words capable and resourceful in dealing with problems and in everyday life.

Deciding to consult or apprentice oneself to a diviner is logical therapeutic-management if one considers that many conditions of illness may be the somatization of the perceived anxiety of a Black working class. It must, however, be emphasized that membership of an igqira network is only one of many ways of coping emotionally and to a large extent, financially, as will be discussed below. Because the functioning of a diviner school depends on close lateral ties with other schools and overlaps with other voluntary associations, it is impossible to study diviner schools in isolation. Supportive voluntary associations such as Manyano groups of many church denominations, Zionist groups, sports clubs, funeral associations, umgalelo groupings (savings clubs) and amakhaya (groups of migrants from the same home area) have been studied by Botto (1954), Mayer (!961), West (1975) and Wilson (1971, 1973), for example. Regular shebeen attendance is yet another important way in which people find companionship with other members of the working class, who have similar needs and aspirations. In this way, township shebeens provide clients with a sense of community and a place to share problems and points of interest. Many people belong to more than one voluntary association, because not all their needs are fulfilled by membership to only one. For instance, umgalelo membership may enable one "to buy a TV set or to keep a child at high school", while membership of an amakhaya enables migrants to identify with a supportive "home-boy" group, which rallies to one's aid in times of need. Membership of a Zionist group may not fulfil all these functions but may provide spiritual healing. Besides formal organizations, street membership and neighbourliness, for example,

imposes a sense of mutual caring and obligation to help one another. Life in Guguletu is precarious, by helping others, people ensure that they too will be helped in times of need.

The supportive amagqira networks, like many other urban associations cut across ethnic affiliation. Thus ethnicity is not an important motivating factor for joining one school as opposed to another. As mentioned in Chapter 4, it is analytically counter-productive in the urban township Guguletu, to attempt to classify any people as being strictly Xhosa, Zulu or Sotho; nor can the amagqira cells be differentiated along ethnic lines.

Although Mrs. A.D. is Xhosa-speaking, for example, and thus calls heself an "igqira", she was originally trained by a Sotho diviner and has Zulu, Xhosa and Sotho-speaking initiates and peers who are welcome to participate at one another's dance-seances. While Mrs. A.D.'s father was "African", her mother was classified according to South African legislation as "Coloured". What is important, however, is that she carries out the healing in the way she perceives to be correct according to her shades. In her school, a Xhosa identity is not necessarily highlighted: however, the African diviner identity recognized right across Africa is emphasized. Anyone who wishes to participate in an igqira network may join provided that one is recognised by the diviner as being "truly" intwaso. Thus one sees that these associations have become increasingly generalized.

It is against a background of interlocking, support networks, radiating beyond households and Guguletu itself, that one particular, vertically organized cell of a wide-ranging network will be studied along with other laterally-linked cells of amagqira and their initiates.

In many respects the diviner school parallels "this-worldly" religious groupings such as the Zionist Church. The following statement is therefore in many respects applicable to an understanding of other supportive networks, of which amagqira are but one alternative.

> "With very few exceptions there is no escaping the environment of poverty. A fundamental anthropological assumption of my analysis is that there is a demonstrable connection between environment and organized behaviour. The pattern is for people to respond to their environment in an organized way. Rarely will it take the form of a single unitary reaction, but rather that of a whole range of collective

> responses to the environment, so that at any time a number of organizational alternatives will be available and individuals can choose amongst them. Thus despite the poverty of the people of Kwa Mashu indeed in direct response to it, there exists a wealth of associational life in the township."
>
> (Kiernan, 1977 : 32).

Peel (1968) also echoes Kiernan's contention that independent churches are "an answer to privation."

Before discussing the merits of the above statements, one cautionary remark needs to be made: namely, that one cannot seek to explain the importance of all supportive networks purely in terms of organization against poverty and its effects, although it is a significant aspect. One also has to understand and analyse the specific functioning and form of the organization itself. It is to this end that the chapter is devoted. But first the nature of the overlap between amagqira and Zionists will be discussed.

The attitudes of amagqira to Zionist groups are divided. Mrs. A.D., for example, encourages her initiates to re-attend their other supportive religious associations, once they have passed beyond the initial stages of training. According to her and some of her peers, one can only become an initiate if one devotes all one's energy to following the wishes of the shades which are made known through dreams.

One can understand this point of view, because the first of the four stages of intwaso discussed below is a separation from one's past role and the adoption of a new one. This clearly defined role, that of a novice, is symbolized by the wearing of white beads and garments which imply purification, newness and a clarity of vision in perceiving the wishes of the shades.

Mr. G's opinion is representative of a diametrically opposed view of Zionists. He believes that many Zionists are really called to be diviners but that "they have run away from it". He claims that when people have put off intwaso, by first going to the Zionists, they usually become more ill.

Mediating these two positions is the idea that it is possible for one to fulfil both roles at the same time; for example, Mr. M. became a Bishop of the Zionist Church at the same time as being an igqira. He claims that his healing power is enhanced as he works through the power of God and his

lineage-shades. The amalgamation of beliefs was not regarded by him or by other Zionist members (unlike members of orthodox churches) as being contradictory. This is because becoming a Christian is considered a personal decision, whereas in his opinion, one has "no choice but to follow intwaso."

The functioning of a cell of a diviner network will be discussed over the time period of the four phases of intwaso each of which corresponds to a position in the vertical organization of the school.

i) perceived illness, the decision to consult, and prophylactic measures at the level of the personal arena
ii) initiation at the level of the folk arena
iii) "five-to"
iv) igqira.

The last three stages are seen to be directly in line with Van Gennep's phases, namely, separation, mediation and re-aggregation, as explained in an analysis of transition rituals (Van Gennep, 1960).

According to initiates, they move from one stage to another "at their own pace", which is determined by "the wishes of their shades." In reality it appears to be determined, not merely by the extent of their recovery, but also by their own earning-capacity or ability to mobilize sufficient family support to enable them to pay for the goat or cow, symbolic of transition to the next phase of intwaso. Either way they learn to become socially effective (ibid), not only within the diviner-community, but also within society.

Because of the extreme poverty of some families, coupled with their isolation, they are unable to afford sacrificial animals or the payment of the diviner's fees which can be about R10 for the divinatory session (vumisa) and R100 for the entire treatment. Hence the paradox that those who are most in need of supportive, lateral links are denied access to the diviner network through inability to mobilize financial support. It becomes clear that initiates can only succeed in becoming diviners if they are able to contribute materially to the diviner community. Those who are structurally isolated or incapable of fulfilling the role-requirements of initiates, may choose to belong to a supportive Zionist group, which is a less expensive

The first phase of inthlombe:

Mrs. A.D. (extreme left) winds on white armbands while she waits with a fellow diviner (wearing a turban), a novice (dressed in white) and a family participant (far right) for the inthlombe to begin.

Novices (dressed mainly in white) and Five-to's (wearing turbans) dance in a circle in the small front room of a Guguletu home.

E., a Five-to who is attending the novice, Beauty (dressed in white) is earnestly overseen by Mrs. A.D.'s sister, who is also a qualified diviner. She holds a dancing stick and whip, symbolic of her disciplinary role. In the foreground is the enamel bowl in which the meat from the sacrificial goat is served. Customarily, the novice for whom the goat is sacrificed, eats first (umswamo). One can also see the frothing ubulawo in the billy-can. In the lower right hand corner one can see the fire. Note the shack built by a migrant worker in the backyard, where the second phase of the inthlombe occurs.

The costumes of initiates are indicative of their stage in the process of intwaso. They are to a certain extent individualistic.

In the above photograph we see that the difference between the costumes of the Five-to's (centre and lower left) and those of the diviners (upper left and right), who have more beadwork and animal skins than the Five-to's.

Children of diviners and novices attend the proceedings.

The final phase of "Beauty's" iinthlombe is held publicly in the street. Note the white dress of the novices who are at the initial stage of intwaso.

option and provides spiritual healing.

For this reason some patients use only parts of the diviner's therapy, such as vumisa or attendance at iinthlombe, where one may benefit by participating merely in clapping to polyrhythmic music. The sensory overload of many people dancing and singing loudly to the accompaniment of a heavy drum beat helps to produce altered states of consciousness as well as supportive, concentrated attention (Janzen, pers. com.).

Some have merely donned the white (1) beads of the initiate themselves in the hope that the shades would be satisfied if they only partly followed intwaso. Others believe that diviners are backward and more trouble than they are worth.

In many instances of perceived intwaso, however, financial assistance is obtained from some family members with the aid of the igqira, who publicly dramatizes the adoption of a sick role and emphasizes to all family members and relevant others: that the sufferer is genuinely ill, really requires the help of the igqira, that the family is not wasting their money or that the sufferer is merely "asking for meat" (an idiom for, seeking attention).

Often support from an igqira is ensured by the use of kinship metaphors. For example, Mrs. A.D.U's help was gained from a sufferer whose name is Umkwayi, because her husband shares the same name. In this way Mrs. U's network was mobilized as a support in time of trouble. Another example can be seen in Case 10: household 3. (see Chapter 4, pg. 84).

Thus it can be inferred that in some instances people who, because of their lack of economic and, or, emotional support during a time of perceived stress, become initiated into a supportive network by using the idion of kinship links. The diviner, whether male or female, must fulfil the supportive sympathetic role of mother. Initially a sufferer of intwaso gains support from their lineage shades whom they use to justify and support their claim for help from an igqira. The latter in turn puts forward the patient's problems and ensures that the sick role is publicly emphasized and accepted. This is of great therapeutic value because it makes it possible for the sufferer to put aside their old role and its attendant responsibilities and stresses. It also helps them to mobilize financial support from relatives. This was made quite clear at an invuma ukupha ceremony (2) held for Mrs. N, at which the illness sent by ancestors was accepted. Previously she had

had the same ceremony performed by another igqira, without any success. Her daughter, who also perceived herself intwaso, however, had been greatly helped by Mrs. A.D.'s school, consisting of about 20 initiates. As a result, the mother also decided to consult Mrs. A.D. Night after night she had dreamed that she was losing her way in dense bush and suffered from severe headaches. For some time her husband had been "going his own way", deserting her for other women, while the children were constantly fighting, partly because of their financial problems and the overcrowding in the home.

As it was the second time Mrs. N. had had the invuma ukupha ceremony, she had saved up her own earnings for a goat, while her family only made a contribution towards its purchase Everyone, including those family members who confided that they had "no time for the amagqira", attended the ritualized drama of becoming an initiate. Mrs. N's eldest brother, standing in place of her father, prayed first for her progress as an umkhwetha while he whipped up the frothing white mixture, ubulawo, with a forked stick. Ubulawo is believed to bring about communion with the shades when one takes it orally or is anointed with it. Afterwards Mrs. A.D. gave her initiate, F, a chance to pray for Mrs. N's recovery, on her own behalf, as this was considered an essential part of F's training. F. is her "five-to" igqira who had worked through intwaso to a stage at which she was almost ready to accept her role as an igqira. Whilst she prayed, she whipped up the ubulawo until Mrs. A.D. took over from her and completed the prayer. Mrs. A.D. boasted lightly about the strength of her ubulawo as opposed to that used by N's brother. Then in earnest she too prayed that there would be "a clear, white open road" for her initiate and that the process of initiation would come in "a clear way because at that time she had truly answered her shades (izinyanya)". Immediately she had finished she raised her dancing stick and articulated her positive message in a song: "Baweyele Amagqira", meaning loosely, "the amagqira have taken you across the river, or saved you."

After this the protagonist made a clear statement of all that had troubled her. She was closely supported by Mrs. A.D. who lead the affirmatory cry "Camagu", meaning in this context, "thanks be in the name of the ancestors." Mrs. N. prayed for all the people in her house, asking that the shades take away the evil that troubled them. Finally, she said that she was truly intwaso and that her sickness was "in the blood" and not merely "a way

of asking for meat". Other informants have claimed the irreversibility of intwaso by saying that "it is given by the shades while one is still in the womb and shows itself only later."

The above vignette of a ritual is given merely as an example of invuma ukupha and the way in which intwaso is used as a means of coming to terms with household stresses. On the other hand the following instance suggests that claiming intwaso can provide one with an entrée to a diviner-school where one learns a new skill which can be profitable, depending on one's ability to tell fortunes accurately.

The material advantage of belonging to a diviner-school was apparent when two novices were seen with their diviner in full dress in a Claremont shopping area, persuading people to have their fortunes told. People flocked around them and it appeared that quite a few shop assistants and passers-by were interested in having their fortunes told. The novices drew attention to themselves by their striking appearance and by praying loudly upon their knees to their izinyanya (ancestral shades) to thank them for their good fortune after their "mother" had bought them some clothes. The diviner explained that because they were her "children" they must accompany her everywhere. Although she is based in Durban, she travels from place to place with her novices, healing all those who consult her.

At the time of my meeting her, she was living at Crossroads. Her novices, described as being intwaso, were being trained in the art of fortune-telling. This would provide them not only with a new identity, that of igqira, and membership in an emotionally supportive network, but also enable them to acquire a skill which could be remunerative. Seeing the way in which they set up their "side show" and attracted attention to themselves, was remniscent of the informal jongleur-genre of wayside and courtyard drama.

We therefore see that the idiom of ancestral possession is used for many different reasons by residents. Although none of the following instances are mutually exclusive, some of them are less important than others under certain circumstances.

(a) to justify the adoption of a sick-role,

(b) to discard a past role and attendant identity,

(c) to ensure a redistribution of wealth and emotional support within one's extended family,

(d) to enable one to adopt a powerful position and to mobilize a wide-ranging mutually-supportive network, and

(e) a way to cope with particular symptoms, because intwaso provides a "culturally patterned" form of expression for perceived illness and misfortune.

Each of the above instances will be illustrated and highlighted in turn by means of the following cases.

a) Justification for adoption of a sick-role

In the first instance, intwaso is used as a form of passive mastery (Turner 1968 : 154). This was clearly Mrs. A.D.'s sister's motivation for using the idiom (Case 9 : household 20, discussed in Chapter 5). E. had suffered a series of cumulatively less well-handled misfortunes and the only way in which she could express her desire to shake off the responsibility of the role of supporter and uncomplaining sufferer, was to use the idiom of possession. This enabled her to justify her desire to be free from responsibility for her children's welfare. Only in this way could she as a deserted wife and mother, leave her children with a clear conscience and become an apprentice to a diviner in the Orange Free State. It is not uncommon for apprentices to put a great deal of distance between themselves and family responsibilities. In this way, not only the ritual of invuma ukupha dramatizes their separation from their past role and their perceived vulnerability, but also their physical separation and distance from all that is troublesome. It is usual for diviners to follow migrants home in order to help them accept their calling at the "place of their shades" and to help them re-affirm ties with their living family members so that they attain a sense of caring and belonging.

Some amagqira, such as Mr. M. and Mr. G. spend most of their time accompanying novitiates on their "pilgrimages" back to their shades, the "source of healing and renewal" (Turner, 1968 : 203), in order to help them re-affirm their kinship ties and to remove a sense of alienation and anomie resulting from dislocation from their extended family.

(In E's case (see Chapter 5, Case 9 : household 20), however, she went alone, not with the intention of re-affirming kin-ties, but to put them aside .

temporarily. With the aid of a diviner, she was able to see her family troubles from a new perspective and to come to terms with them. On her return to Cape Town she became part of a supportive network, in which her sister played a key role. In this way she was helped to become more resourceful than she had believed possible before her initiation.

Irene (see Chapter 4, Case 6 : household 21) went to Zimbabwe for similar reasons, leaving behind her the responsibility of being the breadwinner, a role she fulfilled despite her own ailments. She expressed resentment at times at having to support, with the aid of her husband's meagre pension, his niece as well as her children, when the latter's husband was away renewing his contract in the Ciskei. In the same way, L's mother-in-law, who disliked L's presence (because she did not respect her sufficiently as she was uneducated), perceived herself intwaso, possibly in order to disclaim responsibility for training L as a "housewife" (see Chapter 4, Case 9 : household 20)

L's mother-in-law approached the problem of her own anxiety and the friction which existed between them by using the idiom of possession. This made it possible for her to justifiably seek aid and advice from L's own mother and ensured that L's mother would be sympathetic and concerned. As discussed in Chapter 4, Mrs. A.D. managed to resolve the dispute and restored order and harmony within her daughter's new household.

As mentioned above it is not uncommon for diviners to accompany their would-be apprentices home in order to help them re-order their relationships between their kin, both the living and the shades. The feeling of isolation of Mrs. A.D.'s initiate, Suselina, caused intwaso to break out after her parent's death, but she would not accept it. She felt pains "like needles pricking her" which she interpreted, as a result of her dreams, to be a calling from the ancestors. According to her, she was also unable to look people in the face because she became very withdrawn after her parents' deaths.

She left the Ciskei and came to Cape Town, where her husband lives as a contract labourer, because they had not been making ends meet at home. At that point, she tried to control perceived intwaso by attending Zionist healing rituals, they were, however, of little help. Eventually she apprenticed herself to Mrs. A.D. and ceased to attend the Zionists until she becomes "a qualified igqira". She has had the white beads tied on her neck, wrists and ankles to indicate her obedience to the ancestral calling. The beads were an initial protective measure which were to be worn until Mrs. A.D. returned to the Ciskei with both Suselina and another female migrant,

Esther. Esther, like Suselina, was an illegal migrant who lived in the same shack as Suselina and her husband. Esther had no supportive family in Guguletu. According to Mrs. A.D. "each day the Blue-line bus leaves for the Ciskei, she sends her love to her father". She too had to leave the Ciskei in order to find employment. Mrs. A.D. explained that when she goes to Tsomo she would hold the ritual unvuma ukupha and tell their family that their children "were really true initiates".

In this way, the bond of kinship would be re-affirmed at a ritual sacrifice during which there would be much feasting and dancing. In so doing the underlying resentment caused by feelings of neglect and isolation would be removed. Mr. G. also returns frequently with migrant apprentices to their rural homes, in order to officiate at the invuma ukupha ceremony.

Some migrants with rurally-based families, however, prefer to return to their homes to find a suitable diviner, for example: Mr. B.G. suffered ill luck while working at Koeberg as a contract labourer. He lost his money and suffered from stomach complaints. As soon as he heard from a man of his amakhaya that all was not well at his home in the village, Upper Nega, he returned. His family were sick and his father had been accused of flirting with his wife while he was away. A ceremony of inkomo ye zilo (the cow for the shades) was held to appease ancestral wrath and presided over by a diviner. As a result harmonious relations were restored within the household.

Thus we see that patients' therapeutic networks stretch far beyond Cape Town. Often amagqira spend a great deal of their time travelling. Sometimes as in the case of Mr. M., they travel with their initiates, some of whom who are five-to, help with the healing of other.

b) Discarding a past role

Intwaso, as used to discard a past role and to gain a new identity is particularly clear in the case of F, who was a severe alcoholic and had tried, without success, to control her compulsion. At first Mrs. A.D. was unenthusiastic about accepting F. as an initiate. Only after F. had made many promises not to drink excessively at iinthlombe, did

Mrs. A.D. agree. Much to Mrs. A.D.'s annoyance, F. continues to drink imoderately on occasion, although she had improved. Initially, Mrs. A.D. was afraid that she might be too disruptive an influence in her school and was unsure whether "the beads were right for her sickness". In other words, she was unsure as to whether initiation was an appropriate therapeutic action, or whether F. needed a biomedical doctor. F., at the time of consultation, had been left by her husband who had also been a heavy drinker. After his departure, according to Mrs. A.D., "she began to drink like a fish!" Mrs. A.D. keeps a very wary eye on her and checks up regularly on her activities. If she shows any sign of drinking, Mrs. A.D. gives her herbal medicine with which to purify herself. She also warns her to keep away from all men as their influence, according to her will only hold her back in the process of initiation.

On the occasion of N's initial ritual of acceptance, when F. was to have her first public occasion of leading the prayer, she not only arrived late, but was obviously drunk. Mrs. A.D. berated her, saying that she was going backwards, not forwards, in the way of the amagqira. She went on to say that even though she was a five-to igqira, she had an extremely long way to go before becoming an igqira. As is customany before iinthlombe, she was given herbal medicine with which to wash: however, Mrs. A.D. doubled the quantity both to ensure that she saw clearly the wishes of her izinyanya and that the medicine was unpleasantly strong. In front of all her other initiates, she said laughingly, "I hope the medicine bites you!" Everyone present laughed, making F. feel embarrassed and sheepish. By means of group-therapy, F. has been encouraged to drink less excessively.

V. who has been institutionalized at Valkenberg, (see Chapter 4, Case 10 : household 3) suffered even greater depression after her dismissal from the hospital. By perceiving herself intwaso, she was able to set aside her old role and be initiated into the new role, that of a novice. Previously she had attended Zionist healing ceremonies; these did not help, however, as she had not attained a new identity and still saw herself as being on the verge of a nervous breakdown. Once the white beads had been donned, she felt renewed, as if she were on the brink of attaining a new self. Her opinion of herself improved when both her husband and her father sacrificed two cows on her behalf. In the first

instance the sacrifice was made to appease her maternal ancestors, and in the second, to appease her husband's ancestors. According to V., the second cow was sacrificed by her husband partly because she had brought a new source of income into the home and "he was pleased with her."

Daisy, on the other hand, suffers from tuberculosis: she is also a dwarf with a severely deformed spine, giving her a hunchback appearance. She lives with her mother and grandmother in a matrifocal household. She is unable to work and appears to have little meaning in her life, apart from being an initiate, as she has little chance of filling the roles of wage-earner, mother or wife. Throughout her life she felt isolated because her deformity made her different from her peers. In such a context, the idiom of ancestral possession enabled her to command the support of an amagqira network and through dramatizing her adoption of the role of initiate, being weak and deformed was given new meaning. These symptoms are in fact all seen as part of a very powerful ancestral calling visited upon Daisy so that she would feel compelled to obey their will and become an initiate. Her old identity was set aside by the ritualization of her transition to a new role in which she is treated with care and respect by her family and fellow initiates.

In all the above-mentioned instances, those who are called are expected to cure themselves so that they too would understand the nature of healing and be able to help others heal themselves. Thus through the idiom of obeying their ancestors' wishes, they work through their own perceived illness and achieve health and resourcefulness by coming to terms with themselves, their families and their shades, the last being also the idiom of their own wishes and expressed needs.

c) <u>To ensure a redistribution of wealth and emotional support</u>.

To ensure a redistribution of wealth and emotional support within her extended family, Beauty also used the idiom of intwaso. From an early age she had lived with her uncle (mother's brother) and aunt after both her own parents had died. She was always a moody, withdrawn child and resented her cousins who in her eyes received more care from her aunt and uncle than she did. By the time she was 20 years of age, she had

been doing domestic work for four years. She was extremely unhappy at the home of her employees and felt even greater neglect than before, because she lived in "servants quarters during the week and only returned to Guguletu on Sundays". At this time she began to perceive that she too was intwaso. Each night she dreamed of white beads and the killing of a white goat. Eventually, after having her claim of intwaso supported by Mrs. A.D., her uncle agreed to kill the first goat which would indicate to her shades that she had accepted their illness which manifested itself mainly through the symptoms, umbilini.

Depending on what the shades tell the novitiates in dreams, the minimum of two goats are sacrificed to mark the first stage of "the acceptance" and the second of "five-to". Sometimes more than one goat is believed to be required before the next stage in the process of initiation can be achieved. Finally, one or more cows are sacrificed to mark the last stage, that of igqira. Each animal clearly demarcates the stages of intwaso and the progress made by the initiates.

After the first stages of training, Beauty became less moody, and participated enthusiastically in the dancing at iinthlombe. As a result of her dramatic adoption of a sick role, she became the focus of attention within her uncle's household. He spent over R100 on a goat for her shades, while her aunt bought white cloth and beads for her niece. The entire family participated in cooking and preparing for the iinthlombe. She also received great emotional support and sympathy from Mrs. A.D. and her peers within the school.

Initiates within a diviner school constantly visit one another.. Those who are more advanced initiates take it upon themselves to look after the newer ones. They also visit Mrs. A.D. regularly each week. She trains them and gives them medication, while they are also expected to busy themselves as helpful children in her home. Some bring their sewing, some help her with housework and others sit and make conversation. Nearly every week-end an iinthlombe (healing dance-seance) is held at the home of an initiate, who believes her ancestors require it. On many occasions they, as a school, are invited to the iinthlombe of other diviners' initiates. Similarly, Mrs. A.D. and her initiates are joined by other schools, some of whom are invited, while others simply arrive

because they hear the music, or have heard of the event via someone else. Beauty's network of relevant others, who are materially and emotionally supportive, was greatly extended, while her uncle invested time, money and concern upon her emotional troubles, perceived as intwaso.

d) Adopting a powerful position and mobilizing a mutually supportive network.

As emphasized above, all initiates are trained to become resourceful and independent. At the outset potential initiates muster family support through passive-mastery using the ancestral calling as an idion for self assertion. This is certainly true of both Mrs. A.D., the igqira in charge of a core of about 20 initiates and Mr. G., an igqira who lives nearby to Mrs. A.D., but who does not participate at any iinthlombe. Although he has initiates he does not dance with them but refers them elsewhere, usually to Irene, a five-to igqira who lives opposite to Mrs. A.D. and who, in turn, introduces them to Mrs. A.D. The friction which exists between the schools of Mr. G. and Mrs. A.D., is not unusual and is due to G's larger clientele, greater wealth, and the fact that he concentrates only upon fortune-telling and treatment with herbs. As far as Mrs. A.D., her ppers and the novices are concerned, he is not an igqira, but a witch. On suggesting that perhaps he did not dance because he was an inyanga (herbalist) not an igqira, both he and other informants emphasized that he was called by his shades to become a diviner.

Mrs. A.D. perceived herself intwaso soon after her marriage into which she had entered against her will. As far as Mrs. A.D. was concerned, all her father had wanted was lobola. According to her, she was very unahppy as she did not wish to live with her husband, because he drank heavily and was in her opinion stupid. By means of the idiom of intwaso she justified her leaving Cape Town, and without actually knowing of a diviner in the Orange Free State, trusted that she would find one there. Mrs. A.D.'s sister, E., went to the same igqira on her sister's recommendation.

According to Mrs. A.D., she received directions from a "Pedi" man she met at Phillipi station, to a farm where a reputable diviner lived. She was sure when she met her that this was indeed the igqira of whom she had dreamed. For six months she remained at the home of the diviner, until she dreamed

that she should return to Cape Town because she was "five-to", and that her father should kill a cow for her shades. In this way she gained independence from her husband, with whom she continues to live, but to whom she pays little attention. She also ensured that her father, who had deserted his wife and children for many years when they were young, had remitted no money, but had returned when she was working and forced her into marriage, paid attention to her needs. This motivation for intwaso is similar to that of Mr. G.

Mr. G's perceived intwaso, besides giving meaning to his illness, diabetes, for which he received treatment at the local clinic, also fulfilled the needs of his assertive personality. At the age of about 16, he had become very aggressive, despite his weak physique, and on one occasion, was in danger of being arrested and charged with assault. He had had very limited schooling because he was an ill child and this, combined with his weak physique made it unlikely that he would be able to become a self-supporting labourer. At this stage he began to interpret his illness and misfortune as intwaso. Although his own father was not an igqira, he came from a long line of amagqira in the Transkei. At his father's suggestion he was taken to "Gaba", a well-known igqira in Guguletu, who supported Mr. G's suspicion that he was intwaso. For many nights Mr. G. had dreamed of wild animals of the forest (ihlati) and other culturally-patterned symbols of which the other potential initiates had dreamed (this will be discussed below). In becoming an initiate he worked through not only his own problems associated with his illness, but was able to fulfil a powerful role which has brought him an income far in advance of that of a labourer, or for that matter, most amagqira in Guguletu for instance, he owns not one, but two houses. In achieving wealth by other's standards, he has earned an ambiguous reputation, particularly because he does not associate with other amagqira.

e) Provision of a "culturally patterned" form of expression.

In many instances, intwaso is the meaning given to a functional disorder. Marie H., at the age of about 16, was apprenticed to a diviner in Lady Frere. She had consulted him when he arrived at Burgersdorp where she was living at the time. Her parents had taken her to him to have her fortune told, because throughout her childhood she had suffered from

insomnia. She had also cried frequently and had refused her food. According to her: "I used to be nikkering for nothing" (peevish for no reason).

She was treated for a year but her rapid heartbeat and pain in the right-hand side of her abdomen (umbilini) did not improve, because the igqira was unable to follow her dreams successfully. She decided to return home because the diviner claimed that her mother's and father's ancestors were fighting and he did not know which ones to follow. It is not, therefore, an unalterable rule that diviners are always called by their maternal ancestors, as suggested by Hammond Tooke (1975 : 32). Marie remained at home until she married, but continued to be troubled by umbilini and her dreams; eventually she and her husband separated as she was too preoccupied with her illness. She also went to numerous biomedical doctors who, according to her, all diagnosed her problem as "nerves".

In 1979 she went to Wellington as she had found domestic employment there. On the very first day of work she felt ill and was unable to get out of bed. A medical doctor examined her and gave her an injection, without it having any beneficial effects. She was consequently referred by him to Paarl hospital, but they too did not understand the problem. After they had X-rayed her, they said that there was nothing wrong and that they could help her no further. One of the doctors suggested that she consult an igqira. As a prelude to her becoming an initiate she was treated with ubulawo, the white foaming medicine of the shades. As soon as she felt a little better, instead of continuing with the process of initiation she left Wellington and went to look for work in Cape Town. Not long after she had arrived in Cape Town, she sought an igqira for a third time whom she thought might be able to help her, but he too failed to understand her problem and to follow her ancestors' wishes correctly. She decided to return to her parent's home. They took her to Lady Grey Hospital because her eyes were painful. When she was discharged she did not feel any better, so her parents took her to Mr. M., who was able to understand her illness because his experience of intwaso had been similar to hers. He had also suffered severe umbilini and restlessness and had been afraid of the dark.

It is clear from Marie's case, for example, that in some instances of self-perceived intwaso, legitimation and understanding of one's illness is not easy to find and that corroboration of the perception is also a very important factor of intwaso. Marie went to four diviners before she found Mr. M. who was able to help her because he believed that she was truly called by her shades. In other instances there is much disagreement amongst diviners as to whether someone is truly intwaso or whether (a) they are "just pretending", because it is suspected that they want prestige and the possibility of increasing their income as in the case of Irene, household 21, or (b) that they are not in fact intwaso, but suffering from a severe illness which, in their opinion, should be treated biomedically, as in the case of the daughter from household 2, who was told to go to Groote Schuur Hospital for treatment of TB, before she came to a diviner. Another instance where the perception of intwaso was not corroborated by other diviners, was an instance of a young boy of about 15, who had previously been treated at Valkenberg Hospital for the mentally ill and had, according to other diviners, been incorrectly diagnosed. For example, Mrs. A.D. claimed that he was in fact suffering from "amafufunyana", a condition which would not respond to treatment which was meant only for the condition intwaso.

Once Marie had found a diviner who understood her problem and legitimated her adoption of the role of initiate, she entered the second phase of the training process, namely separation from her past role. This was ritualized by building a small hut out of branches and canvas, near a deep river where she stayed alone for eight days. During that time she prayed to the shades for direction. She "met" her ancestors from the bush and the river and decided to follow first her mother's then her father's izinyanya. This enabled her to clear the way for her to proceed with the process of initiation. After this period of isolation her simple food of mealies and porridge was passed through a small opening. Following this period, the umhlwayelelo, documented in detail by De Jager, Gitywa (1963) and Hammond Tooke (in Whisson & West, 1975) was held, at which gifts and prayers were offered to the Abuntu Bomlambo (frequently translated as River Ancestors).

A great number of ritually significant symbolic aspects need to be

highlighted and discussed at this liminal stage of intwaso. Although the emphasis in this chapter is not on the ritual context itself, it is of vital significance for an understanding of healing within a diviner school. For this reason it will be looked at briefly before concentrating on how, ideally-speaking, a diviner school helps to achieve social healing through communitas engendered, not merely by ritual, but by the emotional and material intradependence of the members.

The ideal igqira is warm compassionate and motherly, even the male igqira is expected to adhere closely to the compassionate, sympathetic role which is not usually reserved for men. It will be argued that at their best amagqira are important social healers who mediate between conflict and order, by bringing clarity and meaning to perceived dis-ease.

This is achieved by "seeing clearly" (uncerstanding) the dreams of their initiates and carrying out the wishes of their shades: by encouraging a client who, like the igqira, uses the cultural idiom of ancestral possession to explain his or her dreams (Bührmann, 1977; Berglund, 1976; Wilson, 1936; Tooke, 1975). In so doing the client is forced to articulate his or her problems and to come to grips with a bounded, defined problem. In a personalized universe speech and ritual orders and controls chaotic forces (Douglas, 1966 : 88), sometimes merely because it produces "dramatic catharsis" (Beattie, 1967 : 230). It is impossible, according to all amagqira (Bührmann, 1977 : 24), to treat anyone until they dream and relate their dreams to an igqira who in turn follows them and attempts to help the initiates fulfil what they claim to be "their ancestor's wishes".

Thus the process of intwaso involves articulating the sense of personal chaos by means of a culturally-patterned idiom. Symbols such as being lost in a deep forest, falling off a high mountain or being drawn into a river by the call of the Abantu Bomlambo, trying to find one's way out of a cave, or being chased by wild animals, are ordered, mediated, controlled and eventually used to the benefit of the initiate (Wallace, 1967 : 189).

Ordering symbols, for example, are the white goat, beads, food and frothing ubulawo, which are symbolic of clarity, newness and purity right across Africa (Janzen, 1982 : pers. com.). These symbols are manipulated by the igqira who knows and understands both the ways of the shades and the river

ancestors. Because the Abantu Bomlambo are seen to be both the givers of knowledge, life and death, they are ambiguous and awesome. They defy rigid classification and the diviner who is closely associated with them is consequently also held in awe. No two informants give exactly the same description of the river people or ancestors, but all are agreed that they are "the deepest part of the igqira-business." They are essentially a key to understanding the above-mentioned symbolism and therefore need to be discussed prior to further analysis of the symbolism associated with intwaso.

According to Mr. M., whose opinion is not necessarily representative of all other amagqira, although other informats' opinions did substantiate it to a large extent:

> "Intwaso comes from the river, now that is why we all go to the river. Because if there was no river there would be no life. The first igqira came from the water, then he/she taught everyone else. The Mamlambo tell the herbs we must get from the bush. Then sometimes they tell who is coming, so that you have the medicine before the people come... we all work through the same power of the water, Zionists and Amagqira. God gives different gifts to different people, but the power is from God."

The Abantu Bomlambo, as far as Mr. M. and his amakhwetha are concerned, are the life-force or living water from which man draws his powers of spiritual healing. Others, however, emphasize the other side, namely, their destructive power to draw people into the river, causing them to disappear or drown.

The power of the symbolic mediation of opposites is discussed by Turner (1967, 1969), Douglas (1966, 1967, 1970) and has been extended by Hammond Tooke (1975 : 27) in his analysis of the mediatory powers of the amagqira, who have both the power of izinyanya (kin with all the qualities of wise, loving elders who transcend the barrier of death, in order to intervene in the affairs of their descendants) and the power of the Abantu Bomlambo, often called "River Ancestors", who are creative, destructive and all-knowing: consequently they embody both good and evil.

An understanding of the importance of Abantu Bomlambo is motivated by Hammond Tooke by means of his interpretation of the relevance of the spatial categories: bush, river and domestic, cultivated areas; Hammond Tooke.

sees the river spatially as mediating between the bush and the homestead, hence their ambiguity:

> "Rivers take their rise in the relic forests of mountains and flow through the grassland and past homesteads."
>
> (1975 : 27).

As such it cuts across the wild and the tamed, or cultivated areas. It is therefore ambiguous, powerful and dangerous in the sense used by Douglas (1966) in her work "Purity and Danger", for all things which defy man's rigid classification.

This elegant interpretation of the mediation of the opposition between "Bush...Wild...Dangerous...Disorganized", associated with wild animals such as the lion, tiger, baboon versus domestic areas "...Cultivated... Tame...Safe...Organized" associated with domestic animals such as the ritually potent white goat and cow, is something of an over-simplification of reality. It is necessary to pay closer attention to informants' models which do not in fact conform exactly to Hammond Tooke's (1975) interpretation. The bush is not always regarded as being symbolic of a threatening place of danger. It is also a place symbolic of retreat from a disordered domestic unit where one may voluntarily meditate, not only a place where one loses oneself. E., for example, described the quietness of the trees and the peacefulness of the river on the farm where she was an apprentice, as giving her a sense of "wholeness or rightness" as she described it. At a practical level, they are also places where diviners spend a great deal of time looking for herbs, praying and meditating. To say that one is "of the bush" or "of the river", is also a form of metonymic speech.

It could be more convincingly argued that the role of the igqira is not to mediate spatial symbols of disorder versus order, as Hammond Tooke (1975) suggested, but to control their <u>ambiguous potential for disorder</u>. Therefore the wild animals (izilo) are not only lions and tigers, for example, but at the same time are merely a <u>form</u> taken by the shades. This is widely understood. What the igqira helps the initiate to do is to highlight the <u>ordered</u> aspects of these <u>ambiguous</u> symbols. In learning to articulate disorder by means of <u>apparently</u> disordered symbols, the initiate discovers their ordered dimension. Thus the igqira's prayer is for her initiate to

see clearly the way through the disorder to the new, clear state. This transition is symbolized by wishing the initiate to be able to follow "the clear white road" or that she be able to cross the river, which as Hammond Tooke rightly said is itself an ambiguous divide.

In addition, the goats and cows are not described as "animals of the shades", merely because they are tame, domestic animals and therefore symbolic of order, as suggested by Hammond Tooke (ibid). Cows and goats which have the same symbolic value of cows, are used to forge links between both the living and the dead; for example sacrifices occur at times of transition in the life-cycle such as birth, marriage and death. The linkages forged with affines and shades are therefore essential for binding together family-members into a united body and thus restoring harmony, the essential pre-requisite for a state of well-being and health. On all these occasions, cows or their ritual equivalent are slaughtered, in most instances under the supervision of the diviner, whose role is essentially to avert social conflict and tension. These links are the key to understanding how the diviner-school fulfills its mutually-supportive function and at the same time, ensures that initiates learn to mobilize support. Hence Janzen's expressed interest (1982, pers. comm.) in the possible linguistic root ngoma traced in the Nguni words, inkomo, ingoma (song or tune closely associated with the rythmic healing dances of the diviner-schools) and sangoma (healer). According to Janzen, in all instances the linguistic root appears to be associated with the meaning "establishment of links".

Besides their sociological importance, cows (or their ritual equivalents) have considerable economic significance. The number of animals sacrificed for each initiate is of considerable importance as it is both a form of status for the novice and is symbolic of the amount of support which has been mobilized by the novice, with the help of the igqira, and the degree to which a new role has been socially affirmed. The tails of the cows attached to the ends of the xhentsa (dancing) stick, are held up in the air at iinthlombe when the owner wishes to stop the dancing and draw attention to her prayers to the izinyanya. Gall bladders of goats, tails of cows as well as necklaces and bracelets made, not only from domestic animals, but a variety of wild animals are worn simultaneously. They are symbolic of the drawing together of both order and disorder into one meaning-system. At another

level, these relics are also a form of conspicuous consumption, particularly in an urban context where a cow can cost up to R300 or more and a goat as much as R85 or more. Animal skins such as that of a lion or cheetah are also purchased at a high cost.

The ancestral shades (3) are usually undifferentiated in the urban setting, possible because of increased generalization of the roles of men and women. The maternal ancestors are, however, often appeased first, and it is important to note that somatization of anxiety symptoms such as umbilini are claimed by some informants to occur most often on the left hand side, the side of the woman. As Sibisi (1975 : 50) pointed out, diviner-hood is "a woman's thing". Although female diviners were in the past, allowed to carry spears as Hammond Tooke pointed out, this cannot be considered to be a symbol of maleness as he suggested (1975 : 22). Formerly, it was used for digging roots and slaughtering animals. Today, the latter function is udually performed by a male butcher in the urban areas. The fact that male diviners often wear aprons and skirts at iinthlombe is, however, symbolically significant, as they are expected to fulfil the caring, nurturant role of a female towards her children, in this case her novices. Mr. "Golden" M., for example, always contributes to the final phase of the iinthlombe, held outside in public view (4), by acting out the role of a woman: in his charade he mimics nursing a baby, stamping corn, sweeping the floor and other strictly female chores. This charade, besides having sheer entertainment value, is also a powerful testimony to his essentially female status, despite his being a male igqira.

Despite female diviners' independence and their powerful personalities, they are not encouraged to behave "like men". Speaking loudly, drinking and smoking excessively or living immoral, immoderate lives is carefully controlled by the informal, negative sanction of gossip. Mr. M. and "Golden" M., for example, both married one of their novices. This is greatly disapproved of by Mrs. A.D. and her female ppers who claim that they had become intimately involved with their female patients, forgetting that they were supposed to have a motherly, caring, platonic relationship with them.

This is only one of many instances where mutual disapproval is either openly expressed or voiced behind another's back, as in this case. Mutual

criticism, as mentioned by Hgubane (1981 : 361), is an important sanction for the maintenance of a moral character and professional standards. There are many people who call themselves amagqira, but are merely laughed at or ignored by others because they are regarded as being useless healers or having immoral characters, as in the case of "Golden" M., who is criticized for his immorality. Others are regarded with a mixture of fear and suspicion, because no one is sure where they fit, in relation to the categories good and evil, while their ambiguity is yet another source of their power (Douglas, 1966). This is certainly so in the case of Mr. C.G. who is suspected of being a witch, yet at the same time has a large number of clients because of his powerful reputation as a healer. It is clear that there is a certain amount of friction laterally between fellow amagqira and vertically with their initiates. Sometimes it is justifiable as it is a form of sanction, at other times it can only be said to be motivated by jealousy and ill-will.

During the process of learning, the renamed novice attains a new identity. Every member of the school has a special name, which in some instances characterizes the initiate and in others is simply used to emphasize the new identity within the diviner school, for instance, Nobulawo, Notshugovu, Nocamagu. Once they have been initiated the novices work their way up from novitiate in the school hierarchy by articulating their dreams which are in turn followed closely by the igqira. When novices percieve themselves to be better, they dream of a more individualistic, colourful costume. This is usually expressed in terms of their shades' pleasure with their progress. The igqira usually makes the costume for both her novices and "five-to's" who have almost reached the hour of diviner-hood. Finally, after more sacrifices have been made, the five-to becomes a fully fledged igqira. It is the prerogative of every igqira to give full range to her imagination as far as her costume is concerned within the general limitations of what constitutes igqira dress. The hierarchy within a diviner school, corresponding to the stages of intwaso is symbolized by means of dress: simple white beadwork for a novice, a more colourful head-dress for "five-to's", and finally the more flamboyant attire of the amagqira. It is possible to devote a great deal of discussion to the nature of their costume, but it would add little to an understanding of the functioning of the school.

Although strict obedience to the igqira is expected, discipline is imposed jokingly, as in the case of F and the herbal medicine, or in the way

a loving mother would scold her disobedient children. Ideally, no one is ever fixed at any point in the hierarchy, because as soon as an umkhwetha dreams that he or she is ready to move to the next stage, the transitional sacrifice and iinthlombe for the shades is held, because it is imperative that the igqira follow their wishes. To become an initiate is therefore to embark on a process of change. Ukuthwasa, means literally to be in a process of change, and is applied to the phases of the moon and seasons. Each stage of ukuthwasa is made discrete by means of ritual and symbolic dress. The "five-to" amagqira, although responsible to the diviner, are in charge of the novices who should be prepared to obey their advice. In instances where a five-to does not use her authority wisely, she is berated in front of the others as one who should know better. In this way, each initiate is given responsibility from an early stage of intwaso so that they learn to become both capable and resourceful.

In the two diviner schools with which I was especially familiar, there was a great feeling of unity amongst the initiates. It could perhaps be described as having a "happy family atmosphere." Novices within the urban area do not live together. They do, however, meet as frequently as possible. Communitas has requested iinthlombe is also important. Great hospitality is extended by the family of the novice who provide the meat, beer, cool drinks, vegetables and cakes for the benefit of all who attend. Participants are also expected to provide food and drink. In this way a sense of intradependence is built up within diviner schools.

The hostility between peers of different schools has been mentioned, but splits may also occur within the hierarchy of a school where a sense of competitiveness exists. A potential split was witnessed in the school of M.C.G. when his "fice-to" novitiate was found to be co-opting his patients without giving him a portion of the fee. There followed a severe argument during which his five-to agreed to remedy his ways.

Despite the fluidity of the hierarchy, splits may occur in much the same way as in independent churches (West, 1975). Once the initiates perceive that the shades require them to move on to the next stage in the training process, their wishes ought to be respected by their diviner. It is the moral duty of all amagqira to follow the dreams of "their children" so that they might "grow according to the wishes of their shades". Ideally, relationships in

a diviner-school are not one's of inferior versus superiors, but one of initiates at different phases of a vertical continuum. The main sanction against departing from these norms is gossip. Diviners who do not fulfil the moral requirements of divinerhood, require a bad reputation and are regarded as being "not truly diviners" or at worst, "witches".

It should also be stressed that diviners, once qualified, are under moral obligation to continue with self-treatment, in order to maintain their healthy equilibrium and ability to heal others. This is achieved with the criticism or support of their fellow diviners.

It can be said that in many respects the diviner school parallels the independent churches, as they provide a close, caring community, within the harsh realities of township life. They can be said to draw together people of similar status and disposition which creases a sense of communitas. Intwaso provides a means of coping with anxiety and an alternative network in which one is taught to become resourceful in day-to-day life.

> "It is not at all certain, however, that the religious generation of pseudo-hierarchies is solely the outcome of structural inferiority. The factor of status reversal is, I am convinced, correlated with permanent structural inferiority. But is may be that elaborately ranked ritual and ceremonial hierarchies represent the liminality of secularly egalitarian groups, regardless of the rank of such groups in the wider society."
>
> (Turner, 1969 : 191).

I have quoted many examples to illustrate how deeply the position in South Africa of the Black population affects their lives. At all levels, from fear of being caught without a pass, to lack of family ties, to lack of a home or living space, to inability to afford the transportation costs to a clinic, the population's health is affected. The diviner schools must be seen in the urban context along with other supportive networks, as a coping strategy aimed at ameliorating social problems.

FOOTNOTES

1. See below a discussion of their symbolic significance.

2. invuma ukupha means loosely, "the acceptance of the illness".

3. I take cognisance of the papers by West (1975) and Hammond Tooke (1978) in discussing the connotations attached to using the word "shades" versus "ancestors".

4. The usage of symbolic space in healing rituals is very important.

CONCLUSION

The focus of this thesis was to re-approach an understanding of the condition, intwaso, by locating it contextually within a range of other illness-episodes suffered by household members.

It was argued that an understanding of the general therapeutic management of residents would provide the necessary background for understanding the natures of intwaso. The central tenet was that without contextualization, a distorted interpretation of intwaso was inevitable, because the construction of research ruled out the possibility of seeing the co-incidental nature of the condition.

At the outset, it was emphasized that at present diviners fulfilled an important role as social healers in an urban township such as Guguletu where every facet of life is affected by structural constraints. It was argued that diviner schools were shaped in response to these environmental needs.

In Chapter 2, the need to study health systems, as opposed to concentrating attention upon separate medical systems, outside structural determinants, was emphasized. The reason being that in the South African urban context, pluralistic systems are considered as part of one repertoire by Guguletu residents. We therefore looked at over-lapping medical systems as opposed to emphasizing boundaries amongst them. Chapter 3, a discussion of Guguletu as a place to live, provided the focusing shot for further discussion.

In Chapter 4 we honed in on a range of illness-episodes and social contexts in which natural or non-natural causes were highlighted. An initial attempt was made to ascertain the reasons why in certain contexts explanatory models highlighted natural as opposed to non-natural aetiology. We saw that in instances when therapy proved unsuccessful or a social situation deteriorated, aetiological explanations could be revised. It was suggested at this stage that social variables appear to influence closely the choice of aetiological decisions.

In Chapter 5 we tested Comaroff's (1981) contention concerning the relevance of the social context in aetiological decision-making, by holding constant

a particular symptom and ascertaining the way in which therapeutic management varies. The relationship was not held to be valid until it was tested in the form of an hypothesis. Chapter 6 was devoted to this end. The relationship was shown to have great relevance for the contextual understanding of intwaso.

It was also emphasized in Chapter 5 that although "the socially relevant" cause may be highlighted, the other causes are not neglected. In cases where the social context does not prevent successful technical control, the underlying causes of the illness are not emphasized.

In this way a discussion of the nature of intwaso was motivated via an analysis of the urban context of therapeutic-management decisions, relating to one symptom, namely TB. In so doing, we see that the understanding of intwaso needs to be re-approached.

The contention held by researchers such as Hunter (1935), Soul (1974), Gitywa (1963) and Laubscher (1937, 1975), for instance, that intwaso has a definite range of characteristics was criticized. We saw that intwaso was not a descriptive lable for a group of characteristic symptoms. If it was, diagnoses would have been consistent, or nearly so, for all the illness-episodes of householders and the varying explanations for illness revealed by the analysis of TB symptoms would not have arisen.

It was argued that intwaso could not be said to be similar to the condition schizophrenia, as suggested by Kruger (1981) and Laubscher (1937, 1975). Intwaso is a more flexible explanation for a wide range of life-experiences. It is also used positively, in order to obtain an entre to a diviner-school, where social resourcefulness is taught; as opposed to enabling the sufferer to become a dependant.

A major distinction hinges on the fact that although the process of exploiting the respective sick-roles may be similar in many respects for both conditions, the end result is considerably different. Initiates gain not only a sense of prestige and independence, but also become powerful members of the community. On the other hand, inmates become stigmatized and dependant. It is therefore conceded that the overlap between the two conditions is far from exact: One cannot compare intwaso <u>in toto</u> with any form of psychogenic disorder.

"Intwaso comes in different ways to all people", said informants. What they did not say, but which could be understood from an analysis of case-histories and illness-episodes, is that the idiom of possession is used for different reasons by aspirants, as discussed in Chapter 6, ranging from passive-mastery to a need for self-assertion. The social context is the determinative control for both perceived aetiology and therapeutic-management. Amongst other uses, we saw that intwaso could be a resource used in stressful emotional or financial circumstances by those who perceive their lives to be in a state of chaos or it would be the meaning imposed by family members or diviners on a series of illness-episodes and misfortunes. Dis-ease is ordered and given form when it is seen as being part of an overall plan, namely, that of an ancestral calling. It is emphasized that although in some instances when the condition is self-perceived it is readily supported by patients and diviners, in others the social recognition of intwaso is more difficult to obtain. Without recognition it is impossible to follow through the calling, because not only is emotional support from family members essential, but the diviner had to be paid a fee ranging from fifty to hundreds of rand to cover the entire treatment.

Thus it becomes clear that only those who are able to muster initial financial support from their family and learn to become resourceful members are able to enjoy the long-term material and spiritual advantages of belonging to diviner-networks. Those who are socially isolated, particularly matrifocal households, and are unable to afford diviner's fees, consult Zionist healers. The reason being that diviner communities are mutually supportive and cannot support members who are incapable of contributing financially either to the feasting at iinthlombe or helping other members materially in times of need.

It was ascertained that those who belong to a diviner-network did not cut themselves off from other voluntary associations, although in the first stages of intwaso it was usual to devote all one's energy to "following one's shades". In this way, form was given to their personal problems and they learned to cope more successfully with everyday life. In order to ensure against most contingencies, novices may also belong to a range of other supportive groups: savings clubs, funeral societies, amakhaya, Zionists and diviner-networks, to mention a few illustrative examples.

In some instances the sufferer was not recognized as being "truly intwaso", despite their protestations, aspirants sometimes have to motivate acceptance by persistently asking to be treated by the same diviner or by consulting others. Decisions as to the suitability of aspirants were based on a number of reasons, ranging from personal dislike to inability to pay fees.

Intwaso is not, however, always regarded as the correct diagnosis for all initiates; those who do not respond to treatment are re-diagnosed and referred to biomedical practitioners by the diviner or the patient's family.

The idiom of possession by the shades is the first step towards building up a legitimatory chain of support and social recognition, enabling aspirants to adopt a new role and to become part of a mutually supportive network. Intwaso may be diagnosed in instances of functional disorder. Under these circumstances, provided the initiate is responsibe to treatment, a new identity and role is attained within, ideally-speaking, a family-type community with wide-ranging links with other similar groupings. If the initiate is unresponsive to treatment, however, the diagnosis is revised to be brought in line with the effects of treatment. It is said under such circumstances that the beads are not right for the patient concerned. In so doing diviners demonstrate an understanding of illness-aetiology. They realize that social healing is not suitable for all conditions and refer such initiates to biomedical practitioners. Thus we see that natural and non-natural aetiological explanations are neither confused nor misunderstood by many diviners in Guguletu.

To summarize, the condition intwaso has been studied within the structural politico-economic context of life within Guguletu and the micro-level of the family-milieu; both of which are essential to the research design. Intwaso in an urban context has become an increasingly generalized condition, co-incidental with a series of less well-handled misfortunes or illnesses and used as an explanation and means of coping with illness and misfortune, which to a large extent stems from poverty and structural constraints.

Further Problems and Possibilities

It would have been interesting to correlate formally, variables such as age, sex, level of schooling, level of income and structure of household, with choice of therapeutic options. It would not, however, be possible to isolate the above variables profitably unless one accounted for the social context of each correlation.

It would be most worthwhile to situate a study of mutually-supportive diviner networks within a study of social reproduction in a township community such as Guguletu. In this way it would be possible to sharpen an understanding of why and at what stage in the demographic development of populations, supportive institutions such as diviner networks proliferate.

GLOSSARY

Abantu Bomlambo : Powerful river people who live in much the same way as the Amaxhosa but who possess the key to all wisdom.

amafufunyana : An indigenous condition caused by sorcery. The symptoms consist of feverishness, delirium, lack of self control and loss of contact with reality. This is believed to be due to the fighting of little men in the sufferer's body.

Amakhaya : Groups of migrant home-boys from the same rural area who associate with one another during their recreation hours and often live together in the same hostel. A fellow home-boy can be relied upon for both financial and emotional support in time of trouble (Wilson and Mafeje, 1973 : 31).

'camagu : depending on the context in which it is used, it can be a greeting, an affirmation of a statement, equivalent in meaning to "Amen", let it be so. Most informants translated the ritual usage of 'camagu as "thanks be to you in the name of the shades". In all contexts it is a reverential term.

Five-to igqira : almost at the hour of becoming a fully qualified diviner. It is the stage of intwaso just prior to becoming a fully fledged diviner.

hlonipha : customary respect.

idinare : a dinner usually held at times of transition in the life-cycle. It is not viewed by those celebrating to be in any way an adherence to "the old customs".

idini : a ritual sacrifice of a goat or cow at times of transition in the life-cycle. It is regarded by the participants as an "animal for the shades".

idliso : poison.

Indiki : an indigenous category of possession by alien spirits, who as a result of not receiving a proper burial, occupy the bodies of living men. They cause the possessed victim a great deal of harm.

igubu : drum

imphepho : dried yellow flowers which when burned are aromatic and used ritually at dance-seances by the diviners.

impundulu : a witch familiar, translated by informants as "a lightening bird".

ingoma : song or tune

(i)inthlombe : therapeutic dance-seance

isiko (s): amasiko (pl) : customs

ixwhele : a powerful herbalist

izilo : literally, "animals" used to refer to the shades who often take the form of animals. Inkomo yezilo viz. means, a cow for the ancestral shades.

Izinyanya (pl) : ancestral shades. Ityala (s) an ancestral shade.

phambana (adj) : mentally ill

phehlelele : to train (a novice)

phuza amanzi : to draw water slowly into the mouth, meaning to accept.

ubulawo (noun) : the foaming medicine of the shades, taken orally and used for annointment of the body. It is considered to bring about communion between the shades and their living kin.

ubuthakatha and ubuggqwira : used synonymously to apply to both witchcraft and sorcery.

ukulawul'amaphupha : to relate dreams

ukuthwasa (verb) : intwaso (noun) 'thwasa (abbreviation) : to be in the process of change. It is applied to changes in the moon and the seasons. "Ukuthwasa ungengonyama" - to thwasa with the help of or through a lion.

ukugula : to be sick

ukufa okumhlophe : a white sickness, a synonym for intwaso.

umbilini : literally, "intestines". When used by those called by their shades, it refers to feelings of pain, anxiety and rapid heart-beat in the chest and stomach regions.

umkhwetha : initiate

umgalelo group : a saving society

ukulukhuhla izilo : literally, "to tempt bach the animals", a metaphor for the shades.

ukuvumisa : literally, "to agree", in the context of indigenous healing it means "to tell someone's fortune".

umlaza : ritual impurity

APPENDICES

SCHEDULE 1 CONFIDENTIAL

UNIVERSITY OF CAPE TOWN

INTERVIEW SCHEDULE SECTION 137 : GUGULETU

Address: _____

Interview No: _____

1 Degree of job satisfaction, eg access / payment / contracts _____

2 Opinion of quality of life in Guguletu, eg buses / rent / housing _____

3 Have you been sick in the past week / month / year

4 What signs, symptoms to you have of sickness? _____

5 What kind of treatment do you receive, if any? _____

6 Why did you choose the above-mentioned healer? _____

7 If no treatment has been received: Do you intend to do anything about this sickness? _____

_____

8 What do you think caused your sickness? _____

_____

_____

9 Is the _____ (chosen healing agency) helping you?

10 If yes: In what way and what results do you expect? _____

_____

_____

11 If no: What will you do next? If anything? _____

_____

_____

12 Who is in charge of therapy (ie who decides which doctor to go to)? ___

_____

_____

13 i Who goes with you? _____

ii Who pays for treatment? _____

14 How do you prevent sickness (ie prophylactic measures at home)? _____

_____

_____

_____

15 What healers do people use when they are sick? _____

_____

16 What is the difference between an

igqira _____

herbalist _____

medical doctor _____

faith healer _____

Zionist healer _____

17 Are there any you wouldn't use? If so, why? _____

_____

_____

_____

CONFIDENTIAL

UNIVERSITY OF CAPE TOWN

INTERVIEW SCHEDULE SCHEDULE 137 GUGULETU

Address	Names of Residents in Household	Sex	Age	Place of Birth	Education Level	Length of Stay in Cape Town	Employment Status
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						

Kinship diagram: Relationships between people in household:

Schedule II : used primarily as a guide to initiate discussions with diviners and novices. It was not referred to during discussions.

name

address

place of birth

level of education

length of stay in Cape Town

nature of employment

- family history and kin ties
- degree to which informant satisfied with quality of life in Guguletu, viz: salary, cost of living, township amenities
- reason for becoming an initiate
- nature of illness symptoms
- the range of medical options used for the treatment of symptoms
- the way in which intwaso is defined by informants
- what happens if the call of the shades is ignored?
- how does one become an initiate?
- degree of perceived effectiveness of chosen therapies
- degree of recovery from symptoms
- stage at which a novice is allowed to treat others
- the extent to which family-management of therapy and participation in therapy itself, is important for the novice's recovery
- the extent to which diviners refer patients to biomedical doctors.

DATA CHART I:

SYMPTOMS

Household

Household	Aetiology	Born that way	Just happened	Bad luck	Assaulted	Too young to be responsible	Ancestral calling	"Rheumatism"	Agent inside poisoning body	Treading on poisonous ground	Inadequate nourishment	"Germs"	Lack of work	Financial worries	Job dissatisfaction	Overcrowding at home	Lack of sleeping space	Bad air	Menopause	Weak heart	Incorrect biomedical treatment	Alcohol abuse	Overwork	Old age	Cancer	Ancestral neglect	Lack of family support	Virus	Witchcraft	Catching a chill	Unhappily married
1 Eldest son retarded, also suffers TB.		X									X	X	X																	
2 Mother unable to speak bec. of head injury.					X																									
Son suffered meningitis.												X						X												
3 Violet cried all day.							X												X											
Son suffered heart murmer																				X										
4 Severe rheumatism and bleeding ulcer.								X														X	X							
Children have coughs in winter.											X	X				X											X			
5 Irene's husband has tonsilitis.									X			X																		
Irene has rheumatism															X									X						
Son had severe leg sore which did not heal.		X								X																			X	
6 Esther has cold symptoms, rapid heart beat dreams of izinyanya.							X				X					X							X							
Husband has stomache troubles.																					X		X							
7 Backache, breast infection suffered by Mother																							X			X				
Children had colds during the winter.											X	X				X														
8 Leonie's father-in-law suffered severe stomache ache.		X																							X					
Wife suffered headaches, high temp.							X																							
9 9 yr old child has decayed teeth						X																								
Younger son came out in skin rash												X																		
10 Mother suffered heart attack. Right side paralysed.		X																						X						
11 Sarah had a tight chest. Coughed blood.											X	X																		
12 Daughter's son retarded	X																													
13 Younger daughter has TB													X	X													X			
14 All children have had colds.											X	X				X														
9 yr old son has TB.			X								X	X																		
15 Joyce's husband unable to pass water.		X	X																								•	•		
Joyce suffers from high blood pressure.							X																							
16 Children have had colds.		X										X																		

	Mother so depressed that she finds difficulty in speaking - since husband and eldest daughter died of TB.					X																									
17	The 2 yr old child has swollen scaly eyelids which are apparently very itchy.			X																											
	Mother is intwaso.																								X						
18	Philip developed a high fever and difficulty in breathing - diagnosed as pneumonia.																											X		X	
19	Faith developed painful cyst in breast.		X																												
	Children in her Aunt's house all have colds.									X	X																				
20	Adelaide perceived herself intwaso, at present has backaches and headaches.					Z							X																		
	Leonie her daughter has a rash on face.													X						X											
	Archie lost job, burnt out car, has to support illegitimate children.			X																					X						
	Godfrey works at a liquor outlet, drinks all the time, wastes money.			X																					X						
21	Jacob is unable to walk because of crippling arthritis.		X																		X										
	Wife twisted ankle unable to rest it because she was working.					X							X																		
	Niece's child is lame.	X																													

DATA CHART II

SYMPTOMS

Household

Therapeutic Actions	Private Medical Doctor	TB Clinic Guguletu	Guguletu Day Hospital	Groote Schuur Hospital	Conradie Hospital	Valkenberg Hospital	Westlake Hospital	Heidevelt Dentist	Red Cross Children's Hosp.	Somerset Hospital	Looked for sheltered employment	Iggira - Apprenticeship	Attending vumisa	Prophylactic measure - donning white beads - home remedies	Attending iinthlombe only	Wearing herbal face-mask	Washing with herbs	Circumcision	Sacrifice of ingubo goat at birth or later	Ixwhele	Zionist Church Membership	Membership of Manyano group	Resting at home
1 Eldest son retarded, TB.	X	X		X							X												
2 Grandmother unable to speak due to head injury.				X																	X		
Young son, meningitis.					X															X			
3 Violet cried all day.						X						X									X		
Son had heart murmer.	X									X													
4 Susan has severe arthritis, overdose of painkillers resulted in ulcer.			X	X																	X		
Children have had colds.			X	X					X														
5 Irene's husband has tonsilitis.	X		X																				
Wife has arthritis.	X		X																				
Son had a leg wound which did not heal.	X		X		X															X			
6 Esther suffers from prolonged cold symptoms.													X	X									
Husband suffers stomach problem.	X												X										
Stokie had backache, breast infection.			X																				
Children suffered from colds.			X						X														
8 Leonie's father-in-law has severe stomach trouble.	X			X																			
Wife intwaso												X											
9 9 yr old son has decaying teeth.								X															
5 yr old son had rash and high temp., suspected measles.									X														
10 Mother suffered a heart-attack, paralysed right hand side.	X				X																X		
11 Sarah has TB.	X	X																				X	X
12 Son of 12 retarded.	X		X	X							X												
13 Daughter of 24 has TB.			X	X																	X		X
14 9 yr old son has TB.			X	X																			
Grandmother wears white beads, suspects intwaso.														X							X	X	X
15 Joyce's husband could not pass water	X									X													
Joyce suffers from high blood pressure	X																						
16 Children have colds.			X																				
Mother severely depressed.													X										X
17 2 yr old has swollen scaly eyes.			X						X														
Mother is intwaso												X											
18 Philip developed pneumonia.	X																						
19 Faith developed painful cyst in breast.			X																				
Children's fevers.			X						X														
20 Adelaide was intwaso, at present has backache and headaches.												X					X						
Leonie, her daughter has a rash on her face.																X	X						
Archie lost job, burnt out car, has to support illegitimate children.																X		X					
Godfrey works at a liquor outlet, drinks all the time, wastes money.																X		X	X				
21 Jacob is unable to walk because of crippling arthritis.			X																				
Wife twisted her ankle, unable to rest it because she is working.			X									X											
Niece's child is lame.	X		X																				

DATA CHART III

House-hold	Past Week	Month	Year and before
1		4 month old baby taken regularly to clinic for weighing and check-ups.	25 yr old son is touched since birth and contracted TB, during the past year The whole family also had conjunctivitis during the past 6 months
2		3 yr old baby girl spent 2 weeks in Conradie when she had a high fever.	5 yr old son spent many weeks in Conradie as he had meningitis. Susan, the Grandmother spent 4 months in Groote Schuur Hospital after she was assaulted.
3			Violet's 26 yr old son had an operation for a heart murmer. Violet spent some time in Valkenberg Hospital as she was suffering from "her nerves", later she perceived herself intwaso
4		Children taken to the Red Cross Children's Hospital and Guguletu Day Hospital for severe coughs & colds.	Susan has suffered reumatism for about 5 yrs. She collapsed at work with a bleeding ulcer which developed as a result of taking excessive doses of pain killer.
5		Irene has developed what she suspects is arthritis in her knees.	Husband suffered tonsilitis, not diagnosed for years. Son had a severe leg wound which did not heal.
6		Esther has had a severe cold during the past month which has reoccured throughout the winter.	Husband has suffered from "stomach trouble" for past year
7		Children taken to clinic during the winter for bad colds.	Mother had penicillin injection for an infection.
8		Since June 1982, husband suffered severe stomach pains, he has operation at Groote Schuur, cancer is suspected by family.	Wife claims to be intwaso.
9		Youngest son taken to Red Cross for sore throat and rash.	Other boy taken to Heidevelt dentist for extractions.

House-hold	Past Week	Month	Year and before
10			At the end of 1981, Mother suffered heart attack. She is now paralysed.
11	Sarah had been diagnosed as suffering from TB.		
12			Daughter's son born retarded.
13			Daughter has TB. Father died of TB 10 yrs before.
14		Grandmother donned white beads as prophylactic measure to "hold off" intwaso. Has not consulted igqira.	9 yr old son has TB. Grandfather died of TB 2 years before.
15		Husband suffered from "shortness of breath".	Joyce's husband was unable to pass water. He was hospitalized. Joyce suffers high blood pressure
16		Children taken to Guguletu Day Hospital for severe colds in winter.	2 yrs before both the daughter and her father died of TB.
17			During the past 2 months baby has been taken to the Clinic for sore eyes. Mother intwaso, attends Zionists and amagqira as she is "five-to".
18			Philip had pneumonia 3 months ago.
19		Chidren taken to Clinic during the winter for colds.	Faith had a cyst removed from breast at beginning of year.
20	Adelaide suffered from an aching neck and back. Archie is suffering from bad luck, lost his job, burnt out the family car has another illegitimate child to support.	Leonie has had a severe rash over her face and neck. Adelaide's mother died of cancer. Adelaide claims Godfrey has also been suffering bad luck. He drings excessively and wastes his money.	Adelaide became intwaso about 20 years ago. Husband had TB in 1964. It reoccured again in 1971. Elsie, her sister also had TB.
			Jacob suffers severe crippling arthritis in his feet. Irene, his wife twisted her ankle and was unable to rest it, because she was working. Her neice has a lame arm and leg and does not attend school.

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