

**Exploring Indigenous Knowledge Practices Concerning
Health and Well-being: A Case Study of isiXhosa-speaking
Women in the Rural Eastern Cape.**

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In the School of Education
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DECLARATION

I hereby declare that *Exploring Indigenous Knowledge Practices Concerning Health and Wellbeing: A Case Study of isiXhosa-speaking Women in the Rural Eastern Cape* is my own work except where indicated, and has not been submitted for any degree to any university or institute of higher learning for examination.

Signed:

Signed by candidate

Helen Yolisa Hobongwana-Duley

July, 2014

Dedication

This thesis is dedicated to my parents, Aaron and Monica Hobongwana and to my grandparents Wilson Kulile Hobongwana and Miriam Ntumpuse Hobongwana.

ABSTRACT

This thesis explores, analyzes and conceptualizes the indigenous knowledge practices concerning health and well-being held by different generations of women and how they are reproduced cross-generationally in a rural isiXhosa-speaking community. It also explores how the relationship between concepts of self, personhood and Ubuntu informs women's agency. Additionally, this thesis explores how the indigenous knowledge practices might have the potential to augment inclusive and relevant tools for learning for young women, girls and youth.

This study adopts a critical, holistic and interpretive approach through an ethnographic case study. Qualitative data was gathered over an 18-month period, through ethnographic observations, informal interactions, semi-structured interviews and one focus group. Observations provided insight into the social structure of the community, women's agency, and indigenous knowledge practices that support well-being. They also brought a greater awareness of the ways in which Ubuntu philosophy is embedded within indigenous practices that support individual and collective wellbeing. Interviews created a deeper understanding of women's agency and the choices women make regarding well-being, and how knowledge practices are reproduced.

Evidence from this study is presented and findings are analyzed drawing from Giddens' critical theory, with emphasis on social structure and agency, the philosophy of Ubuntu, Engeström's Cultural Historical Activity Theory (CHAT), literatures on indigenous knowledge practices and systems, and theories of informal and situated learning, in three chapters, each dealing with "the ecology of the homestead"; "health practices"; and "childbirth and childrearing" respectively.

Central findings indicate that indigenous knowledge practices are usually reproduced informally through rituals, ceremonies, and everyday tasks and skills for living within the homestead and are often situated in communities of practice. Other findings indicate that women choose biomedicine for childbirth while also using indigenous practices for health and well-being; NGO outreach workers and mentors often act as 'boundary workers', helping to narrow the boundaries between activity and knowledge systems. However, knowledge that is reproduced in more formal settings such as school often results in gaps in knowledge reproduction, especially among youth.

Due to multiple knowledges being harnessed and reproduced simultaneously, this thesis concludes that different knowledges are practised, are valued and are integral to the choices women make around well-being, which illuminates the value of indigenous knowledge practices in facilitating cultural identity and ontological security. This thesis contributes to theories of knowledge and how knowledge and knowledge reproduction may be viewed and understood, particularly with regard to informal learning. These insights can be applied to developing curricula that acknowledge and are inclusive of indigenous knowledge practices, processes of informal knowledge reproduction and multiple knowledge practices or ways of knowing.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Treatment
BBA	Born Before Arrival
CDC	Center for Disease Control and Prevention
CHAT	Cultural Historical Activity Theory
CNE	Christian National Education
C-Section	Caesarean Section
DoE	Department of Education
ECE	Early Childhood Education
HIV	Human Immunodeficiency Virus
IKS	Indigenous Knowledge Systems
LO	Life Orientation
OPD	Outpatient Department
NEEDU	National Education Evaluation and Development Unit
NGO	Non-Governmental Organization
NVP	Nevirapine
PMTCT	Prevention of Mother to Child Transmission
PNMM	Corrected Perinatal Mortality Rate
TB	Tuberculosis
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION TO THE STUDY

In Xhosa¹ cosmology, one's health and well-being and fortunes in life are connected to the state of one's relationship with the ancestors and one's family relationships being in good standing (Jansen, 1973). In Xhosa culture, possessing the vital force *Amandla* is essential for well-being and encompasses physical health, a thriving family and healthy livestock. To have good health one must have *impilo* (fullness of life) and be in balance with the cosmic vital force (Jansen, 1973: 38).

Set against the backdrop of a deeply rural Eastern Cape community which is rich in Xhosa culture, yet is impacted negatively by poverty, poor infrastructure and lack of transport and roads, the concern of this research lies in the enactment, validation and renewal of indigenous² knowledge practices regarding the spiritual and physical health and well-being of isiXhosa-speaking women. My focus is primarily on women's spiritual and physical well-being, as expressed through the individual cultural world of the physical body in relation to the collective cultural worlds of other bodies in the social structure of the community. My interest lies in the ongoing decisions women make as cognizing and thinking subjects who are learning, unlearning and relearning practices they develop in their daily lives towards cultivating and maintaining their personal and collective well-being. This interest takes its substance from Wiseman and Brasher's (2008) claim that our ability to maintain well-being is dependent on the deliberate relationships we cultivate within our social structures, rather than on the level of our symbolic or economic comforts. Thus, this study aims to show how these inter-personal, body-to-body relationships stretch from the ecology of the homestead to decisions concerning health practices, to ways in which women raise and socialize their children, creating a holistic framework from which to live by.

¹ I use the term "Xhosa" to mean Nguni people who speak Xhosa although many of the people in the research location identify themselves as 'Xhosa' or belonging to "Xhosa culture".

² The term "indigenous" will be explored and defined in Chapter Two.

In a case study of a rural isiXhosa-speaking community, the research set out to explore the social and intellectual processes relating to continuity and change in indigenous common knowledge concepts and practices concerning general health and well-being held by different generations of women, and how they were reproduced and utilized cross-generationally. This research also explored how women's agency gave expression to notions of well-being. Furthermore, I investigated how concepts of personhood, and in particular, "Ubuntu", informed well-being and these "life-skills" epistemologies. Additionally, I was interested in how these epistemologies were utilized in the contexts of the elder and younger women's lives and whether their knowledge was reproduced in informal or formal settings.

Underpinning this exploration was the question of how these indigenous knowledge practices might show potential for helping to augment inclusive and culturally relevant tools for learning for young women/girls/youth. Important too was an interest in how this knowledge can transform more formal educational environments to build more positive identities and alleviate some of the disjuncture between home and school. While my interest was related to education, this is a research study that aims to uncover indigenous knowledge practices concerning health and well-being, rather than a study of educational curriculum.

The theoretical and conceptual framework used to analyze the indigenous knowledge practices in this study were drawn from a wide body of literature that included critical social theory, literature regarding indigenous knowledge, interpretations of the philosophy of Ubuntu, Cultural Historical Activity Theory (CHAT) and theories of informal and non-formal learning.

Indigenous Ways of Knowing and Education

My interest in indigenous knowledge practices stemmed from my initial concern for the well-documented loss of indigenous knowledge practices across the globe (Houndtondji, 1997; Maila & Loubsa, 2003; Ntuli, 2001; Odora Hoppers, 2001; Semali, 1999; Semali & Kinchloe, 1999; Smith, 1999; Viergever, 1999), and specifically in South Africa, and my desire to find ways in which indigenous practices could be incorporated into educational settings.

Throughout history, indigenous populations across the world have shared the experience of being dominated and oppressed and having many areas of their knowledge diminished, devalued or destroyed (Semali & Kincheloe, 1999: 22). This has been the impetus that has led to the creation of organized global resistance movements such as the *Indigenous Peoples' Project* (Smith, 1999: 107), emphasizing the value of indigenous ways of knowing and indigenous knowledge systems.

The focus of many scholars, particularly within indigenous communities, has often been geared towards the effects of the systematic breakdown and gradual erosion of indigenous knowledge practices, a consequence of politically driven decisions initially emanating from the north towards indigenous peoples of the south. More recently, this has also been seen in decisions made by governments in the south itself.

Formal education systems in many countries seemed to have done little to acknowledge the value of indigenous ways of knowing, or the possibility of them augmenting educational environments. This trajectory in formal education appears fundamentally to be about a “reluctance to explore the critical relationship between indigenous values and knowledge systems and modern schooling” (Breidlid, 2002: 38), and seems to be the direction in which South Africa is heading too. This direction led Breidlid (2002) to examine and critique the 2005 South African

curriculum initiative, Curriculum 2005³ (C2005). His research in the rural Eastern Cape came to the conclusion that the efforts to create an inclusive curriculum, embracing all South Africans and planting the seeds for a national identity, fell short of truly embracing indigenous cultures and values (Breidlid, 2002: 45). Although C2005 acknowledged the importance of reclaiming indigenous ways of knowing, especially in the area of language and natural sciences, it failed to explain comprehensively how these ways of knowing could support educational transformation (Breidlid 2003: 89). Rather, C2005 committed schooling and the whole education project to an uncritical modernist epistemology, and consigned indigenous ways of knowing to the periphery (Breidlid, 2003: 91). Issues such as those reflected in C2005 are what Semali and Kinchloe (1999) contend are ways in which “academic gatekeepers” dismiss the possibility of indigenous ways of knowing having the potential to contribute to the well-being and educational experiences of all students (Semali & Kincheloe, 1999: 15). This reluctance by “academic gatekeepers” towards indigenous practices being included in South African education was undoubtedly connected to the impact and residue from the apartheid era, as in the inherent racism and prejudice and the idea that indigenous knowledge practices were “primitive” and not as valuable as “Western” science or education.

Impact of Apartheid on Education

At the heart of apartheid education was the educational philosophy of “Fundamental Pedagogics”, a variant of Dutch existentialism. Propping up this existentialist view of the world was its ontological anchor, the ideology of “Christian National Education” (CNE) (Higgs, 2008: 5). CNE essentially propagated the idea that distinct social groups held distinct views of the world and that the purpose of education was to support the wholesomeness and integrity of these views of the world. Because Afrikaners were Christians, and especially Christians of a certain type, they structured the education process for themselves, and for others, around their

³ C2005 was initiated by the Department of Education in 1997 and revised in 2001.

religious beliefs. Schooling thus came to play a very particular role in asserting their dominance. "Schooling was central for the reproduction of the relations of domination and subordination" (Soudien, 2003: 2), and was essential for keeping the science of colonialism and white supremacy in place, thus benefitting the minority, the white middle- and upper-class populations (Odora Hoppers, 2002: 1). In 1953, the Bantu Education Act was implemented with the intention of ensuring that black learners received an education that would grant them limited opportunities in the dominant white world in which they lived and permanent membership in the working class (Ocampo, 2004: 1). This is reflected in the following quote from Dr. Hendrik Verwoerd, the South African Minister for Native Affairs, from 1950 to 1958:

There is no place for [the Bantu] in the European community above the level of certain forms of labor...what is the use of teaching the Bantu child mathematics when it cannot use it in practice? That is quite absurd. Education must train people in accordance with their opportunities in life, according to the sphere in which they live (Verwoerd, 1953 in The Bantu Education Act 1953, Act no 47).

Throughout the country, education was segregated, inadequate and inappropriate, particularly for learners who were classified as non-white. The curriculum at the time promoted discrimination across racial, gender and class lines (Bredlid, 2003: 84), resulting in students' learning environments being sub-standard and often out of their cultural and personal contexts (Odora Hoppers, 2001: 74).

When South Africa became a democracy in 1994, all schools were opened to all ethnic groups and cultures. However, because the common practice was for neo-colonial societies and governments to internalize and place more value on the educational discourses of their colonizers (Houndtondji, 2002: 25), and to devalue traditional and rural life styles, many students continued to struggle with adapting to the "mandated acculturation" that was expected of them (Odora Hoppers, 2001: 74). Furthermore, South Africa is aligned with global industrialization and values from the North, supports a neo-liberal economy, and has not emphasized a focus

that draws upon Indigenous ways of knowing and valuing traditional culture (Odora Hoppers, Moja & Mda, 1999: 235).

This direction became particularly evident in South Africa, when the government adopted an outcomes-based curriculum: Curriculum 2005 (C2005), with the initial intention of implementing a curriculum that would support the transformation of the society in the country's new democracy (Breidlid, 2009: 144). However the overarching principles and policies that drove C2005 were not always practised in classrooms, especially in rural areas. Unforeseen challenges resulted, particularly with regard to learners having to learn in a language other than their mother tongue, that is, English, and having to overcome the cultural barriers between home and school (Breidlid, 2009). In his research in several isiXhosa-speaking rural communities in the Eastern Cape, Breidlid (2009) found that teachers often compensated for the areas that students had difficulty comprehending by reverting to isiXhosa or by having to "code-switch" and "code-mix" in order for them to teach complex components of the curriculum (Breidlid, 2009: 96). Learning in a language other than one's mother tongue is regarded as counter-productive as insight and meaning are usually from one's own culture base (Murithi, 2009: 224). Some of the consequences resulting from learning outside of one's cultural base are that they can lead to an embedded system of devaluing one's own innate intelligences, resulting in alienation from one's language, culture and ways of knowing (Odora Hoppers, 2001: 74).

Developing an Idea for a Thesis

Issues similar to those mentioned above struck a chord in me when I was visiting my parents in the Eastern Cape in 2004 and was facilitating some leadership development workshops with ninth-grade students at a local high school. I noticed that classroom environments were very strict and seemingly authoritarian in that lessons were given in "lectures", with very little room for discussions. Moreover, almost all the teachers were "white" in a school where the student body was made up of mostly African students. The students I worked with spoke to me about their

struggles with having to cope with what they described as the racism that was embedded within the curricula and in their teachers' attitudes. At the same time, I also became aware of the limited curriculum being implemented at a local historically "coloured" primary school and of the generally impoverished school environments as a whole. This stimulated my interest and made me wonder about what changes could be made and particularly about what aspects of local indigenous knowledge practices could be included in educational settings that might support a more culturally significant experience for students.

Although there have been enormous changes since the end of the apartheid era's educational discourse of segregation and inequality, there still seemed to be a need for transformation in South African education environments towards ones that were more inclusive and utilized local indigenous knowledge practices (Breidlid, 2009; Ntuli, 1999, 2001; Odora Hoppers 2000, 2001, 2002). Huge gaps exist between poor and affluent schools, resulting in disparities in budgets and educational opportunities for learners (Breidlid, 2003: 100). According to several scholars (Breidlid, 2003; Le Grange, 2007; Odora Hoppers, 2001), the post-apartheid schooling system, whether government run or privately run, is modelled after modernist, colonial and neo-colonial ideologies, which do not value local indigenous knowledge systems and are often authoritarian in structure. Many teachers still treat students entering school as *tabula rasa* and consequently disseminate knowledge in such a way that they "participate in the collective, but sub-conscious[ly] [too in the] process of subjugating local indigenous values and suppressing the authentic cosmologies of the very context within which the school is located" (Odora Hoppers, 2001: 75). For indigenous populations, this can mean discord between expectations and culture at home and those at school (Hayes & Siegruhn, 2005: 4).

This non-inclusive climate seemed to be growing as new policies were being developed within the Ministry of Education. According to a *Daily Dispatch* newspaper article I read in 2010, the National Education Evaluation and

Development Unit (NEEDU) was poised to roll out a new standardized national test for children in grades 3, 6 and 9, which the Minister of Basic Education claimed would increase literacy rates for children across the country in Mathematics, English and Afrikaans. While improvements in literacy rates are necessary, standardized testing is a derivative of “Western” education, and does little to transform an education system to one that embraces different ways of knowing. Hence I agree with Breidlid (2002, 2009) and Odora Hoppers (2001, 2002), who contend that to transform education in South Africa to a system that is relevant for all learners and especially for rural learners, local indigenous knowledge practices, or ways of knowing, need to be included in curricula. This would not only provide a context that could liberate generations of South Africans but could also help sustain the communities in which they live (Breidlid, 2009: 147). Furthermore, by discounting indigenous histories, cultures and epistemologies, educational curricula portray a world-view that “prevents a critique of the present neo-colonial epistemological legacy – the hegemonic world system and its oppressive features” (Breidlid, 2013: 57).

Integrating indigenous knowledge in education has been successful in various educational settings across the globe. Burford, Ngila and Rafiki (2003) emphasize the success of Aang Serian Community College in Arusha, Tanzania, where efforts have been made to maintain a balance between “indigenous” and “Western” knowledge, skills and teaching methods. Le Grange (2007) argues for performance education and the “doing” of science, and to situate the learning in the context of local indigenous settings. Gregocic (2009) notes the success of Zapatista pedagogy based on “productive learning” and “learning by teaching” in Chiapas, Mexico, which utilizes “knowledge and abilities from the world and entwines them back into the world and environment where it appears” (Gregocic, 2009: 360).

Incorporating indigenous knowledge practices or ways of knowing into the South African education system’s curriculum has been discussed in academic arenas, but little has actually happened. Exploration and research are still being conducted to

identify these knowledge systems and to see how best they can be applied in educational settings (Breidlid, 2009; Le Grange, 2007; Maila & Loubser, 2003; Odora Hoppers 2001).

The Relevance of Life Skills in Education

The incorporation of Life Orientation Skills (LO) into learning areas of South Africa's C2005 was an attempt to support students in gaining the skills necessary to navigate their way through life successfully, especially as so many youth are considered to be at risk (Prinsloo, 2007: 156). The Department of Education (DoE) outlines that the aim of the LO programme is to prepare learners for life, developing the skills necessary to live a successful and meaningful life in a changing society. The approach is holistic in scope in that it focuses on the interrelatedness of social, personal, intellectual, emotional and physical growth, and recognizes that there are a variety of knowledge systems including indigenous knowledge. Skills are developed in the areas of knowledge, values and personal attitudes, so that learners can make educated decisions regarding their health, social development, personal development, physical development and orientation to the world of work. Learners are expected to be able to contribute to their family, community and society and be able to accept differences between peoples, cultures and religions and actively participate in building a democratic society (DoE 2008). Emphasis is placed on developing "the self" in society with the goal of developing "balanced and confident learners who will contribute to a just and democratic society" (Prinsloo, 2007: 156). Areas of study fall into several categories, which include the following:

- Religion, where emphasis is placed on internalizing religious values from knowledge about the diverse religions within South Africa.
- Socialization and communication, where emphasis is placed on development of the self and forming a positive self-concept as well as developing communication skills.
- Respecting diverse cultures, living in harmony and participating in community life.

- Life skills, where the focus is on navigating through life while utilizing different media as resources, and developing technological skills such as computing and exploring career options.
- Survival skills where emphasis is placed on healthy life styles, preventing injuries and violence and crime awareness and prevention. (Prinsloo, 2007: 157)

Although the LO programme is broad in spectrum and encompasses many of the skills needed for life beyond school, Prinsloo (2007) argues that schools often have difficulty scheduling the LO programme. Teachers face challenges implementing the programme because they are not necessarily trained in the areas of the LO curriculum and often lack classroom resources. Furthermore, many of the learners are not inspired to learn because of adverse life circumstances (Prinsloo, 2007: 164). This is due in part to teachers not being able to implement the programme in the areas that have personal well-being as an outcome. They have trouble understanding and empathizing with the learners' home cultures and life experiences (Prinsloo, 2007: 166) and, according to the DoE (2008), less emphasis is placed in schools on implementing LO curricula than in other subject areas. Despite the challenges facing the implementation of the LO programme in schools, the programme does show value for a variety of knowledge systems and recognizes indigenous knowledge systems that have developed over thousands of years. It also gives reference to traditional practices at various life stages, traditional authorities, traditional belief systems and indigenous games.

Research Focus

This study sets out to explore, analyze and conceptualize continuity and change in the indigenous knowledge practices concerning health and well-being held by different generations of women and how they are reproduced cross-generationally in a rural isiXhosa-speaking community. It will also explore how the relationship between their concepts of self, personhood and Ubuntu informs their personal

agency and well-being.

AIMS

- To explore and describe the indigenous knowledge practices being utilized in the community.
- To understand how the indigenous knowledge practices are reproduced across generations.
- To understand how women cultivate well-being through their daily indigenous knowledge practices.
- To understand how concepts of self, personhood and Ubuntu influence or inform well-being practices and agency.

Motivation and Purpose for the Study

While reflecting on my experiences as an educator in several different cultures and countries, I saw parallels between what was occurring in South Africa and what had occurred in other parts of Southern Africa and Hawai'i. I thought about how educational curricula were usually Eurocentric in scope and generally not geared towards learners of diverse backgrounds. More recently in Hawai'i, where I have lived and worked as an educator for over 17 years, I realized that many educators in mainstream education were not serving the needs of the majority of Native Hawaiian students as well as students of other backgrounds. Students were not being taught in ways that were congruent with their cultural backgrounds and identities, and curricula were missing key elements of relevancy. While efforts were made by the Hawai'i Department of Education (DoE) to bring aspects of diversity awareness for making learning relevant, they always seemed to fall short of becoming the norm for teachers to really access and create inclusive curricula. This led me to want to begin exploring how to support students of diverse backgrounds within a Hawaiian context and how Hawaiian ways of knowing could play a key role in the educational experiences of students in educational settings. It also propelled me to focus the research for my MEd on investigating the experiences of African

heritage students in Hawai'i's public schools, because I had noticed while working in the secondary public school system that the curricula reflected very few aspects of African American culture outside of slavery, which often gave students of African heritage negative self-concepts. Furthermore, African Americans were generally represented in negative stereotypes through the media and in popular culture.

During this period, developments in Hawai'i's public schools and indigenous education programmes were growing in leaps and bounds in creating and promoting culturally significant learning opportunities, particularly through the Charter School movement, where Hawaiian language immersion schools and alternative learning opportunities were created (Meyer, 2001).

From my observations, discussions with other teachers and participation in professional development opportunities, I learnt that students seemed to be particularly motivated when involved in culturally significant or culturally based learning activities in informal learning environments or formal classroom settings. Examples of this kind of learning included Hawaiian language and literature, traditional dance and chants, natural sciences such as ocean studies and fishpond management, growing traditional foods, place-based history and social studies, including family genealogies and health. While these learning opportunities have been successful for many students, there were still huge gaps in the general public school system. These professional educational experiences and my research in 2003⁴ helped generate my interest in looking at how African students were dealing with educational changes in the new South Africa.

As an African woman who has deep roots in the Eastern Cape province of South Africa, and as a daughter of an isiXhosa-speaking political exile, but also, simultaneously, being well aware of being an "outsider", I felt a profound sense of responsibility to help improve and transform educational opportunities in rural

⁴ Unpublished thesis: Duley, Y. (2003). "Searching for the Tribe": The experiences of African heritage students in Hawai'i's public schools.

areas that feature some of the indigenous knowledge practices of the isiXhosa-speaking people. I therefore began interrogating more deeply some of the debates surrounding indigenous knowledge and how they might augment education in South Africa.

Evolution of New ideas and Analytic Constructions

Initially, much of my reading about indigenous knowledge emphasized the displacement and loss of indigenous knowledge practices as a result of colonialism and its residue of ongoing coloniality and the inevitable participation in consumer society. However, as I broadened my reading and engaged in discussions about the debates concerning indigenous knowledge practices, it became clear that many indigenous practices are living testimony of continuously evolving cultures and are embedded in the everyday living practices of individual life-worlds.

In 2004, South Africa adopted a National Indigenous Knowledge Systems Policy in an effort to foster recognition and value toward Indigenous Knowledge Systems (IKS) in public and academic arenas. This policy called for the integration of IKS into education, agriculture, health, the sciences, social sciences, law, languages, commerce and arts (Green, 2007: 130). It was, however, considered to be limited in scope and critics of the IKS policy called for an even broader recognition of IKS that would include multiple indigenous knowledges expressed within methods of farming, house building, food preparation, healing modalities, technologies such as mining, and “indigenous geographies” (Green, 2007: 132). More complexly, despite its limited scope, it came with the rhetoric that it was creating an African Renaissance. This helped to ignite heated debates regarding what constitutes legitimate scientific knowledge within academic institutions, especially in relation to traditional healing methods and AIDS treatments in South Africa (Green, 2012).

Many of the global scholarly debates surrounding indigenous knowledge have aimed to move beyond merely recognizing and valuing that knowledge. Instead,

they begin to address the essentialist Cartesian dualisms that dominate knowledge production, such as nature-culture, mind-body, and bring to the forefront the notion of “knowledge” as consisting of multiple or different ways of knowing that can be expressed simultaneously, rather than in competition with one another.

It is with this view in mind that this study investigates to what extent the indigenous knowledge practices concerning the well-being of rural isiXhosa-speaking women support their physical and spiritual well-being and are integral to the social structure and integrity of the community and evolving individual life-worlds. This study also investigates to what extent indigenous knowledge practices are valued in the wider macro context and to what extent the many life skills related to health and well-being are integral to the identity and cohesion of indigenous individuals and their communities. Furthermore this study explores whether indigenous knowledge practices are expressed side by side with other forms of knowledge and how we might view this knowledge and knowledge reproduction in academic arenas.

Locating the Research

Because my interest lies in the indigenous knowledge practices and concepts of health and well-being amongst isiXhosa-speaking rural women, I chose to conduct my research in a rural village community in the Eastern Cape Province, which is rich in Xhosa culture, yet is impacted negatively by poverty, poor infrastructure and lack of transport and roads. According to some statistics regarding the research community, approximately 1% of the population has access to electricity and running water and 60% have had no formal schooling (NGO website).⁵ The research community will be described in more detail in Chapter Four.

Statistics from the Eastern Cape General Household Survey revealed the following statistics:

⁵ I have omitted the name of the NGO website to provide anonymity to the community and participants.

Eastern Cape General Household Survey 2011

Social Grants	Bucket Toilets	Access to piped water Onsite/offsite	Reliance on rivers or streams	Cook with Paraffin	Cook with wood	Grow food to supplement diet
38.5%	17%	74.8%	25.2%	16.7%	19.3%	90.6%

Table 1. Source: Statistics South Africa Release PO318 [http:// www.statssa.gov.za](http://www.statssa.gov.za)

Developing Contact with Women in the Eastern Cape

From my observations of women in rural communities in Southern Africa and in the Eastern Cape of South Africa, women are usually the primary caregivers of children, youth and the elderly and therefore spend much of their time with these members of the community. It is this cross-section of rural life that inspired me to explore how women impart knowledge amongst each other within and across generations and community settings, and how they may support one another in various contexts, especially around issues of health and well-being.

While first visiting the village community where I conducted this research, I primarily met women who were taking care of young children. It was my hope that through these women I would be able to connect with other women and gain insight into their lives in the community. While I was conducting this research, I volunteered at a NGO providing support to early childhood education programmes in the immediate and outer communities. This gave me opportunities to build relationships with several women, either connected with early childhood education, the NGO or the hospital. Through these relationships, I was able to build trust and be offered opportunities to begin my exploration of the indigenous knowledge practices.

Historical Context

Historically, the area where this research was conducted was settled by isiXhosa-speaking people who migrated south from Natal in the early 1800s (Jansen, 1973). For purposes of confidentiality it is referred to as Mzingisi in this research, The British took power in the area in 1879, when some of the Mission settlements were annexed to the Cape Colony.

The mines in the Kimberley and Witwatersrand areas arose out of the discovery of diamonds in the 1860s and of gold in the 1880s. Unskilled workers from the region began migrating in the early 1900s after the devastating cattle-killing⁶ episode that took place in the 1850s. The people were directly affected by the deadly rinderpest epidemic in 1897 that destroyed hundreds of thousands of heads of cattle, and by the East Coast Fever that hit in 1910 (Jensen, 1973). People left the area and first sought work in the Natal region on farms or sugar plantations, and then on the mines. Jensen (1973) argues that the ongoing impact of men between the ages of 18 and 50 leaving the area for work was devastating for local families and clans.

The impact of migrant labour on...life cannot be overestimated. Their manpower in the vital period of life (18-50 years) is continuously withdrawn from their tribal society and mobilized on the labour market under European supervision. (Jensen, 1973: 15)

More recently, in the contemporary period, large numbers of men and women seek migrant work outside of the area, with men mostly working on the mines in the Rustenberg area, and women often seeking domestic work in Johannesburg or other large urban areas. These migrant workers' lives are split between two life-worlds, an urban life and a rural life. Dependent as they are on the workers' income, both worlds are deeply constrained (Kapelus, 2012).

⁶ The "cattle-killing episode" refers to the tragic historical event and story of Prophetess Nongqawuse, who had a vision in 1856 of strangers appearing out of a pool of water, telling her that the people's ancestors would resurrect and great abundance would follow if they killed all their cattle and destroyed all their maize. It is thought that the cattle-killing was a logical response to the devastation of colonial expansion and to minimize the spread of a deadly cattle lung disease (Mndende, 2006; Mostert, 1992).

The Village Community

The community of Mzingisi has at its centre a government-funded hospital, which was originally founded in 1956 by the Dutch Reformed Church. The hospital provides 150 beds and a broad spectrum of services to the approximately 130,000 to 140,000 patients it serves each year (NGO website, 2010).

This research constitutes an ethnographic case study of the Mzingisi community and the indigenous knowledge practices surrounding health and well-being, based on and from the perspective of several generations of women across various contexts. In financial terms, Mzingisi is considered to be a very poor community. It has high levels of unemployment, limited infrastructure and a high incidence of HIV and TB.

Outline of the Thesis

In Chapter Two, I review a wide body of literature and provide a framework for exploring the social human actions and relationships within the context of the Mzingisi community. I interrogate the critical social theory of Anthony Giddens, and show how the philosophy of Ubuntu, literature on indigenous knowledge practices and Cultural Historical Activity Theory (CHAT) are necessary to provide a broader understanding of the social structure of the community and the ways in which the women conduct their lives. Chapter Three provides a detailed description of the analytical framework and methodology. I discuss the rationale for the methodology used, the number of participants, a detailed description of how I collected data, how I analyzed the data, and ethical considerations. Additionally, this chapter discusses the limitations of the study. Chapter Four gives a detailed description of the ecology of the homestead and shows how the complex physicality of daily living practices are linked to the well-being of the individual and the community. I describe various practices that are chosen to create and maintain physical and spiritual well-being, including how marriage aids in the well-being of the homestead. Chapter Five gives a detailed account of the various health practices that are utilized to cultivate and maintain well-being and shows that the choices made regarding health practices are shaped by and drawn from the different knowledge practices available, which

operate side by side, rather than separately. Chapter Six provides a detailed descriptive account and analysis of childrearing and socialization practices as an example of one aspect of health and well-being. This chapter shows how women utilize both indigenous practices and biomedical practices for their well-being and how the continuously evolving social structure is related to links to the past, present and future. Chapter Seven provides a detailed analysis using CHAT to lift out and peel away some of the complexities surrounding the health and well-being of women in this community. I analyze three themes in an attempt to make sense of the decisions that women make regarding:

1. Using biomedicine almost exclusively for childbirth.
2. Remaining subject to the patriarchal system.
3. Using indigenous rituals and ceremonies to cultivate and sustain well-being.

CHAPTER TWO

REVIEW OF LITERATURE

The aim of this thesis is to understand how the social condition of well-being as an ontological feature of everyday life is reproduced, learnt and relearnt. In order to illuminate the idea of well-being, this chapter draws from a wide body of theoretical literature. The approach taken in this thesis is that the phenomenon of well-being is expressed via the purposeful choices that individuals make each day, and that integral to this choice-making is agency. It is for this reason I draw from the classic literature on agency, especially the work of Anthony Giddens whose critical social theory accounts for the individual in society more articulately than most other social theorists. Giddens' critical theory provides me with an ontological approach so that I could view the reality of daily life in Mzingisi as a function of both structure and agency.

Giddens (1984) contends that the relationships between people are formed by the social structure in which they live, but are not pure reflections of that social structure. Society cannot be read off the life of an individual, or vice-versa, but features of that society can be found within an individual, and the individual will be more than just an image of the society that he or she forms a part of. Giddens' critical theory, however, is based on European sociologies, and in this rural South African context does not explain adequately the stories of people's well-being. I therefore draw from literature on the sociology of Ubuntu, an African "philosophy of life" that informs everyday social choices and conduct. Here, I review different interpretations of Ubuntu and show how Ubuntu constitutes an alternative ontological and in many ways epistemological approach to the Cartesian dualisms of subject-object, mind-body and nature-culture, and is integral in the development of personhood and to the well-being of individual and collective life-worlds.

I also draw from literature on indigenous knowledge and review some of the debates concerning interpretations of knowledge production and argue for a different view of knowledge, from one that embraces the European-centred epistemology of “knowledge as science” to a broader epistemology that views knowledge as multiple practices or multiple ways of knowing. Drawing from both the literatures regarding Ubuntu and indigenous knowledge provides me with an epistemological approach of how to view knowledge and its relationship to culture and history in the context of the Mzingisi community.

I then review literature regarding health and well-being and show that there are various interpretations of well-being and that many societies seek methods and practices to keep aspects of their physical and spiritual selves in balance and maintain their individual or communal health and well-being.

Next, I turn to literature regarding knowledge reproduction and how it is learnt and relearnt. Here I draw from theories of informal and non-formal learning and suggest that much of the learning and reproduction of indigenous knowledge will need to be related to local context and relevancy and be situated in communities of practice.

Finally, I turn to Cultural Historical Activity Theory (CHAT), to form a theoretical and analytical framework to guide my analysis so that I am able to unpack more deeply the social world of the women in this study, and peel away some of the seemingly invisible layers that are buried within the cultural, historical contexts of their individual and collective lives. CHAT mirrors Giddens’ approach in the sense that one has to look at both agency and structure to be able to gain deeper insights about the community. CHAT also provided me with a detailed set of conceptual tools to assist me with my analysis of learning and education.

Social Structure and Agency

Giddens' theory of structuration underpins this research as it explores ways in which women's concepts of health and well-being are influenced by the various relationships they have with others, and how their different roles as women are expressed within the social context of the village. Giddens (1984) contends that the social sciences are hermeneutic and rely on interpretation, and that all social research contains aspects that are cultural and ethnographic. It is with this in mind that I have conducted this work as an ethnography and draw on Giddens' theory of structuration as the conceptual framework for guiding this study (Giddens 1984: 2008: 284).

Giddens (1984) developed the theory of structuration as a framework for investigating human social actions and the relationships between those actions and the institutions and structures within which they lived. Structuration provides "a conceptual scheme that allows one to understand both how actors are at the same time the creators of social systems yet created by them" (Giddens, 1991: 204). Structuration embraces all the social relations, structures and practices across time and space within all societies (Connell, 2007: 34) and rejects the dualistic notion of social "phenomena" being controlled by an objective societal construct or by individuals acting autonomously. Instead, it posits that human agency and social structures are mutually engaged, continuously being constructed through the living of everyday, daily practices (Jones & Karsten, 2008: 129). Structuration transcends the dualism of subject and object, and the idea of structure being separate from human action, by realizing that structure is "an intersection of presence and absence", and as such represents a duality of structure (Giddens, 1984: 16). Giddens also rejects other interpretive sociologies such as Schutz's phenomenology and Garfinkel's ethnomethodology because their focus was on action rather than on structure and did not confront issues of "constraint, power and large scale social organization" (Jones & Karsten, 2008: 131). Thus his adoption is one of a post-empiricist and anti-positivist approach (Jones & Karsten, 2008).

When analyzing social structures, one needs to take into account the various contexts in which knowledgeable actors are situated, and how those contexts are produced and reproduced through the actors' various interactions with one another (Giddens, 1984: 25). Giddens' idea of structure implies there are rules and resources "implicated in the production and reproduction of social systems". His rules are "normative elements and codes of signification" (Giddens, 1984: xxxi) and operate at three levels: structures of signification, domination and legitimation. Structures of "signification" are always viewed in relation to domination and legitimation because they reveal the roles that people play through identifiable, "signifiable" aspects such as types of clothing, which identify a specific profession, like a police officer's uniform; structures of "domination" provide further clues to the roles people play and the individual power that they hold; while structures of "legitimation" have rules or codes that demand specifics about what is an appropriate aspect or code for a particular role or position of power (Jones & Karsten, 2008: 129). Giddens' resources are either authoritative and stem from the activities of human agents, or allocative and stem from the "control of material products, or aspects of the material world" (Giddens, 1984: xxxi). Giddens contends that structure can be both constraining and enabling but can "stretch away, in time and space, beyond the control of any individual actors" (Giddens 1984: 25).

From the perspective of this research, the aim was to determine how these three levels of structure are reflected in the roles and day-to-day activities of individuals as well as the community as a whole, and the extent to which living in the context of the village community influences specific behaviours and expectations of an individual or group. In Giddens' terms it is about investigating how the external or physical world affects action and how the social structure influences social practice (Jones & Karsten, 2008: 132).

Human Agency

Human beings are knowledgeable agents who depend upon and utilize their knowledge in their ongoing navigations through life and in their daily actions. “Human social activities, like some self-producing items in nature, are recursive...to be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked to elaborate discursively upon those reasons” (Giddens, 1984: 2). Giddens (1984) theorizes that humans act as purposeful reflexive agents whose actions move in a “continuous flow” of conduct through time and space. Whilst consciously monitoring their own actions within the environments that they engage with, actors are also monitoring the actions of others, and vice versa. From a structuration perspective agents are capable beings, and although conscious, their actions can have unintended outcomes and consequences. Giddens names these unintended consequences as “causal loops” which work their way back across time and space and “reconstitute the initiating circumstances” (Giddens, 1984: 27). As capable beings, humans have the inherent power to act, which can in effect influence the actions of others, or “a specific process or state of affairs” (Giddens, 1984: 14). Giddens’ (1984) human agents navigate their way through their daily interactions tacitly aware of the rules or codes of social practice and always have a choice about how they act. However, they do not always have control over the consequences of their actions. Human agents’ day-to-day production and reproduction of social practices draw from the social practices of the macro social systems. Individual power then exists as a “duality of structure”. Rather than being owned by society or the social community, actors exercise power to draw resources through their interactions within their social structures (Giddens, 1984: 282). This thesis is concerned then with how the women in a particular rural community reproduce the knowledge practices that inform and influence their lives in relation to the social structure within which they live.

Agency and Knowledge

Giddens (1984) posits that human agents know a lot about the functions of the social structure in which they live because they are constantly interacting and participating within it. He identifies three areas of knowledgeability:

- Discursive consciousness: the actors' verbal descriptions and interpretations of the conditions of their actions.
- Practical consciousness: what actors know but cannot put into words about the complexities of their life-worlds (tacit knowledge).
- Unconscious sources of cognition (James & Karsten, 2008: 133). This refers to the stores of knowledge that actors hold but do not always have conscious access to.

Connell (2007) points to Giddens' theory of the agent as one that is active and knowledgeable, emphasizing that members of society are constantly engaging in complex and diverse life experiences, and are able to navigate through and within these experiences because they possess knowledge that "is integral to the persistent patterning of social life" (Connell, 2007: 35). This is illustrated in her quote of Giddens:

The knowledge of social conventions, of oneself and of other human beings, presumed in being able to "go on" in the diversity of contexts of social life is detailed and dazzling. All competent members of society are vastly skilled in the practical accomplishments of social activities and are expert "sociologists". The knowledge they possess is not incidental to the persistent patterning of social life, but is integral to it...Human agents always know what they are doing on the level of discursive consciousness. (Cited in Connell, 2007: 35)

Human beings also know tacitly how to operate through life without necessarily being able to verbalize that knowledge. These are often routine daily activities, which help to construct ontological security within one's social life, and are what Giddens terms as "practical consciousness" (Giddens 1984: xxiii). However, when one acts in life without really consciously knowing why, such as when one is being

impulsive, Giddens describes this as acting with “unconscious motives/cognition”, which can often have unintended consequences (Giddens, 1984: 8).

Constructing the Self

Giddens’ structuration encompasses “intersecting planes of temporality”. These are found in the *durée* or the temporality of day-to-day life; Heidegger’s “Dasein” – the directionality of the human lifespan from birth to death; and the “*longue durée*” – the temporality of social institutions (Jones & Karsten, 2008: 133). Underpinning one’s identity is the ongoing production and reproduction of structure, which continues through the flow of day-to-day actions of individuals within that structure. This flow of life cycles through months and seasons, and over time, agents build their identities day-by-day, or year-by-year, developing their personhood throughout their lifespan. Giddens said that “all social systems no matter how grand or far-flung, both express and are expressed in the routines of daily social life, mediating the physical and sensory properties of the human body” (Giddens, 1984: 36).

This thesis is concerned with how people cultivate well-being through the physical and spiritual knowledge practices utilized in the flow of everyday life. Furthermore, it is interested in the ways aspects of those practices in relation to the social structure contribute to their individual personhood.

Limitations to the Theory of Structuration

In her book, *Southern Theory*, Connell (2007) emphasizes that within a social context, agency is dependent on the present social order, and likewise, the social order is dependent on the agency of actors. Connell supports Giddens’ theory of structuration because it transcends the dualist notion of subjectivity and objectivity, but she critiques the fact that structuration assumes universality across time and space because it fails to represent the colonized world (Connell, 2007: 34). In the context of this research, drawing from Giddens’ theory of structuration could help us to understand some aspects of the social system I am exploring. However, this

theory would not necessarily be able to lift out and bring into view some of the ongoing effects of colonialism and apartheid, from a South African perspective, because Giddens does not theorize “colonization” or present-day imperialism as its structuring principle (Connell, 2007: 37). Some of the questions this research aims to answer in relation to these issues are: To what extent has the community incorporated into its structure the inherited impact of colonization, the direct impact of apartheid and more recently, the impact of living in a newly democratic country oriented towards capitalism and the neo-liberal global economy? What then are the behaviours, beliefs, principles and practices that constitute well-being, both individually and for the community as a whole, and what perceptions of self play a role in the concept of well-being? To lay the foundation for answering some of these questions, the following sections will address the philosophy of Ubuntu and personhood, followed by literature concerning indigenous knowledge practices.

Ubuntu⁷

The notion of Ubuntu, is a fundamental African philosophy and manifests as a living expression of human dignity and collective personhood. Ubuntu serves as a resource in the form of a “set of practices” or as a “way of life” conducive to well-being, aspired to by many individuals and communities within South Africa (Nkondo 2007). This research explores the extent to which individual and collective concepts of Ubuntu are expressed through communalism, reciprocity, human dignity and compassion in the everyday lives of the participants in the Mzingisi community and whether and how these concepts relate to the well-being of individuals, households and the community as a whole.

Ubuntu has been described as “a philosophy of life” that informs everyday social conduct and includes personhood, humanity, humanism and morality (Mokgoro 1998: 2). Ubuntu emphasizes respect for people’s lives, conscientiousness, solidarity

⁷ Much of this section was cited in Hobongwana-Duley, Y. 2011. The potential of Ubuntu: The possibilities for life-giving. In *Contested ecologies: Natures and democracies in the global south*. (Workshop Papers compiled by Green, L.).

within the community, reciprocity, care, hospitality and contributing to the well-being of the whole community (Mnyaka & Motlabi, 2005). Concepts of Ubuntu are expressed in all South African languages, such as *botho* in Tswana, Southern Sotho and Sepedi; *uvuthu* in Venda; *uvunhu* in Tsonga; *ubundu* in Ndebele and *ubunftu* in Swazi (Masina 2000: 181). Concepts of Ubuntu are also found in other African languages, such as *umundu* in Kikuyu and *umuntu* in Kimeru in Kenya; *bumuntu* in kiSukuma and kiHaya in Tanzania; *vumuntu* in shi'Tsonga and shi'Tswa in Mozambique; *bomoto* in Bobangi in the Democratic Republic of Congo; and *gimuntu* in kiKongo and giKwese, spoken in the Democratic Republic of Congo and Angola respectively (Kamwangamalu 1999: 2); and *hunhu* in Shona (Madzima 2010).

The concept of Ubuntu is drawn from a network of collective African knowledge (Nkondo: 2007), and embraces both spiritual and physical elements of human existence (Masina, 2000: 169). Ubuntu encompasses all elements of society, recognizing the dialectical in human existence, and so transcends the binaries of “either/or” conclusions and embraces “both/and” conclusions (Masina 2000: 170). Ubuntu serves as a set of practices constituting care for others outside of the family, into the micro and macro communities and beyond.

Both Bhengu (1996) and Ramose (1999) describe Ubuntu through their interpretations of Xhosa and Zulu cosmologies. African humanity is referred to by isiXhosa-speaking people as: *umzi ka Ntu*: the family or descendents of Ntu (an ancestor). They, as well as Zulu-speaking people, believe that a person could not be separated from his/her existence in the cosmos, which is expressed in the following terms: *ulotho*: a phenomenon; *uluntu*: the vital force; *umuntu*: the personification of Ntu, the person; *isuntu*: humanity; and *Ubuntu*: the art of being human. And so in this sense Ubuntu is the expression of the continual “becoming” of a human (Bhengu, 1996: 2), beyond just the present here and now, or as “be-ing becoming” (Ramose, 1999: 52). In reference to David Bohm’s philosophy of knowledge, Ramose (1999) interprets African ontology and epistemology as belonging to the same

reality, in the form of “a continuous wholeness” that is incessantly flowing. He states:

It is enfolded⁸ be-ing before it manifests itself in a concrete form or mode of ex-istence of a particular entity. Ubu- as enfolded be-ing is always oriented towards unfoldment, that is incessant, continual concrete manifestation through particular forms and modes of being. In this sense ubu- is always oriented towards -ntu. At the ontological level, there is no separation and division between ubu- and -ntu...they are mutually founding in the sense that they are two aspects of be-ing as a one-ness and an indivisible whole-ness. (Ramose, 1999: 50)

This continual flowing is vital for developing one’s personhood over a lifespan.

Ubuntu in Relation to Personhood

Theories of personhood within Africa are complex but reflect understandings of the collective self as opposed to the autonomous self. It has been argued that concepts of the autonomous self are strictly a European construct and do not play a role in African societies, and are often contested outside of European modernity (Comaroff & Comaroff, 2001). From the perspective of Ubuntu, the concept of self is one that is perceived as being tied to the perceptions of others and that to become human, or to achieve personhood, one has to be perceived as having those qualities that entitle one to one’s humanness (Kamwagamalu, 1999: 25). Within Ubuntu, “the collective sovereignty of the group guarantees the individual sovereignty or primacy of the person” (Bhengu, 1996: 3). This means that the individual does not have to give up his or her self for the collective, but rather considers the collective in his or her individual choices and journeys in life. One has to show the community, through “be-ing”, that one is a manifestation and embodiment of “ubu-ntu” (Ramose, 1999). As such, Ubuntu sets the foundation for a cohesive social structure. This is often illustrated through the daily activities of people within a community, where solidarity or family orientation is manifested in acts of compassion, respect and human dignity, where people exist and live with the aid of others (Mokgoro, 1998).

⁸ Ramose is referring to the quantum and relativity theories of David Bohm.

Because personhood and identity are validated by the personhood of another person “the quality of Ubuntu is manifested in every human act which has community building as its objective orientation” (Mtuze, 2003: 100). This is illustrated in the isiZulu term: “*Ubuntu, ngumuntu ngabantu*”, which literally translated means: “a human being is a human being because of other human beings”, that a person’s existence and well-being are connected to those of the group (Mokgoro, 1998: 2). By becoming the other person, “one has attained a deeper, fuller identity than that of his limited ego-self which is only a fragment of being” (Mtuze, 2003: 101). Therefore, the essence of Ubuntu is expressed through an individual “owing his or her personal existence to the existence of others” (Kamwagamalu, 1999: 25).

Venter (2004) argues that for one to be considered human one needs to possess core elements known as “*umzimba* (body, form, flesh); *umoya* (breath, air, life); *umphefumela* (shadow, spirit, soul); *amandla* (vitality, strength, energy); *inhliziyo* (heart, center of emotions); *umqondo* (head, brain, intellect); *ulwimi* (language, speaking); *Ubuntu* (humaneness)” (Venter, 2004: 150).

There are also barriers to Ubuntu, which transpire from the effects of the brutality wielded against people during the apartheid system. Many people have been wounded and traumatized and are not always able to access the internal resource of Ubuntu. This is evident in the high levels of violence reported especially toward women and children. When one acts inhumanely it is said that one lacks Ubuntu (*akanabuntu*), or is not a person (*akangomntu*) and therefore is unable to identify their own “inner state of being” (Mnyaka & Motlhabi, 2005: 224). However, at the same time, Ubuntu also allows for a person to regain the potential of becoming human because a person cannot be thrown away like trash (*umuntu akalahlwa*) (Bhengu, 1996: 5)

Mokgoro (1998) cites Kunene (1996), who emphasizes the need to look beyond a superficial interpretation of Ubuntu and to view it as “the very quality that

guarantees not only a separation between men, women, and the beast, but the very fluctuating gradations that determine the relative quality of that essence...the potential of being human” (Mokgoro, 1998: 2). Antjie Krog (2008) calls this element of Ubuntu “interconnectedness-towards-wholeness”, an element that moves beyond mere relatedness, a becoming that incorporates both a mental and physical knowledge that all beings, including the ancestors and the universe, are aspiring to reach their fullest selves (Krog, 2008: 354). This potential of being a human is constructed over a lifespan and beyond, with fluctuations of highs and lows. To maintain harmony between the spiritual and physical aspects of life one has to have “close and sympathetic” relations within the social structure and be able to work through challenges that are presented in everyday life (Mokgoro, 1998: 2).

Personhood

This research explores individual and collective concepts of personhood, particularly as they relate to the philosophy of Ubuntu. It also seeks to understand how these concepts play a role in supporting the health and well-being of individuals and that of the collective community.

In Christopher’s (2007) critique of Charles Taylor’s “The Moral Topography of Self”, he highlights theories of culture and identity. He argues that when combining Martin Heidegger’s (1962) view that people’s lives are “structures of care” and Charles Taylor’s (1988) theory that people exist in “moral topographies”, it transcends the binaries of culture-self and fact-values and shows a different perspective of “how culture is a moral frame-work in which people are embedded” (Christopher, 2007: 170). Christopher suggests that Taylor uses “moral” in broad terms and includes notions of dignity and life having meaning, as well as what it means to be “good, worthy or desirable” (Christopher, 2007: 172). Taylor contends that different cultures, subcultures and individuals access “moral sources” or norms to guide their selves into a “configuration of cultural values” (Christopher, 2007: 173). By accessing these “moral sources” they are able to assess and gauge their

development of personhood. Christopher emphasizes that personhood is constructed throughout one's life through developmental levels of knowing or "interactivism", which are "cognitive capacities" that can be accessed at any given moment (Christopher, 2007: 178). Each level of knowing is accessed over a lifespan beginning at infancy when it is implicit, and continuing through adulthood when it is explicit, causing "agency to be distributed across the levels" (Christopher, 2007: 178). Hence we are an "embodied agent immersed in social practices" that reflect our values and moral sense (Christopher, 2007: 179).

Arriagada (2009) argues that we exist as beings embedded in the world, meaning that questions we have about ourselves are derived and answered from that context or "framework" of embeddedness. Moreover, the space in which we dwell as humans influences our moral and spiritual direction, intuitions and reactions and "translate[s] into physical manifestations, for example, that of human dignity" (Arriagada, 2009: 21). According to Arriagada (2009), a set of "unarticulated assumptions" lies behind our self-identity and concepts of how meaning is manifested in our lives. These "assumptions" delineate where we are situated in space, which is linked to our personal and familial historical context, including our ancestors.

Kwasi Wiredu (2009) presents the concept of personhood from a generalized African point of view articulated through the oral tradition, as one that minimally constitutes a combination of the physical body, life force and personality with divine energy emanating from the Supreme Being. Wiredu posits that personhood is expressed within African societies through a system of values, which include moral boundaries and behavioural customs, with communalism being the overarching philosophy. Individuals are connected through familial networks, which span out into the larger community, where a system of reciprocal obligations and loyalty exists. In reference to African philosopher Ifeanyi Menkiti, Wiredu emphasizes that personhood is only recognized in adults as something that is achieved over time and can be gained or lost. When personhood is diminished, the community recognizes

that the individual needs support in gaining or regaining his/her personhood (Wiredu, 2009: 16). Wiredu concludes that within the oral tradition, certain meanings and concepts are articulated which cannot be translated in the written word, hence there are discrepancies in translations from African philosophy to Western philosophy. These differences in expressions of language are present in African concepts of achieving personhood, which are bound up in communalism, versus Western concepts of personhood, which depend on expressions of individualism.

Katherine A. Snyder (2002) examines the concepts of personhood from the perspective of the Iraqw of Tanzania who view personhood as a lifetime construction formed through lineages of kinship and everyday activities of events and exchanges. Personhood is dependent on individual agency and the relations forged within the community. Emphasis is placed on rites of passage such as birth, circumcision and marriage, which help to shape a person throughout his or her life. Persons are linked physically via the matriarch through blood and via the patriarch through bones, which creates a web of relations through which a person can express agency. The achievement of marriage, which is dependent upon the whole community, indicates that a person is fully an adult. Snyder emphasizes that the impact of post-colonialism and modernity have influenced relations to expand further into the macro community, such as to the church. Schooling has also influenced concepts of personhood towards individualistic and global identities. As a consequence, "hybrid" identities are formed whereby personhood is still expressed through relations within the communal context as well as through livelihoods expressed through education and employment in the outer world.

My concern in this research is to explore to what extent modernity and living in the neo-liberal global economy has impacted the participants' concepts of personhood, Ubuntu and their agency.

Robert Storrie (2003) explores personhood and notions of well-being from a Venezuelan Hoti perspective, which is similar to concepts and values of African ontologies. He contends that distinctions between the interior, exterior and self are not obtuse and that body and mind are not perceived as separate entities. Humanity expands to relational networks in the whole of the natural environment and cosmos. "Persons for the Hoti are potentially inter-permeable in both their corporeal and incorporeal aspects, changing and shifting through their interactions and lived experience" (Storrie, 2003: 415). Hoti notions of well-being are expressed through the relationships with their everyday encounters and existence, striving for egalitarian relationships so that there is "emotional comfort in everyday life", with an absence of anger and discordant behaviours (Storrie, 2003: 416).

Similarly, in India, Mines (1988) notes that the structure of society is hierarchical. Indians perceive themselves as active agents with a sense of autonomy, but belong in a society that devalues individualism because people are bound to the collective whole. "The person is a composite of transferable particles that form personal substance" and therefore is considered "dividual" rather than "individual" (Mines, 1988: 569). Personhood can be gained through the regulation of particle exchanges between persons. Conforming to the group, the family and caste, means that a sense of self is bound up with group identity, and a sense of individual identity is lost. Fear of losing the ego and ultimately the self, juxtaposed with the fear of being separated or cast out by the group, due to autonomy, is a dilemma that many Indians face. Maintaining a balance can be achieved through the practice of *ashramadharma*: the four stages of life and the performance of one's duties according to each stage. Similarly, within the African context of personhood, non-conformity to the community and the inability to achieve personhood leaves the individual without possessing "humanness" or the perception of being a person.

Indigenous Knowledge

There have been many debates surrounding the discourse of knowledge that have often focused on how knowledge is constructed, whether knowledge outside of “Western science” such as indigenous knowledge has value, and how political decisions across the globe have affected indigenous populations in devastating ways. The notion of indigenous knowledge has been contested to gain legitimacy and recognition, and to transcend the essentialist Cartesian dualisms that have dominated knowledge production such as nature-culture and mind-body. As a result of these debates, many global scholars have suggested that knowing and understanding consist of multiple knowledges that can complement each other rather than being in opposition to one another. I agree with these scholars and aim to explore the relationship between indigenous knowledge practices in society and how these indigenous knowledge practices inform the way we should view knowledge.

Who is Indigenous?

In recognition that there are several layers of indigeneity within South Africa, with the oldest indigenous peoples being the San, I use the term “indigenous” in this research to mean the Nguni language group of African people who speak isiXhosa. The indigenous knowledge practices explored and referred to in this thesis are specifically those of African isiXhosa-speaking people in the rural Eastern Cape province.

Indigenous Knowledge Systems

Indigenous knowledge systems (IKS) have been defined as “...the combination of knowledge systems encompassing technology, philosophy, social, economic, learning/educational, legal and governance systems” and are embedded in the historical and cultural tapestry of indigenous people that forms the basis for their “social, economic, scientific, and technological identity” (Odora Hoppers, 2001: 76). In the words of Odora Hoppers:

IKS stresses...the essential interrelatedness and interdependence of all phenomena – biological, physical, psychological, social and cultural. Indigenous cosmology centres on the co-evolution of the spiritual, natural, and human worlds. (Odora-Hoppers, 2002: 6).

While IKS form the base for information unique to cultures that are dynamic, they are also influenced by internal and external influences and are constantly evolving. While many interpretations suggest that IKS are local and traditional because they generally support local issues and solve local problems, it is important to emphasize that they can also be utilized to attend to broader, complex global or universal issues (Maila & Loubser, 2003: 277).

In the context of South Africa, it is vital to consider some of the possible impacts that factors such as colonialism, modernity, apartheid and more recently, the aftermath of apartheid, have had on South Africa and how IKS have adapted and shifted over time. For instance, how might the forced removals from ancestral lands have impacted indigenous knowledge practices in South Africa, when many practices are linked to the land and social structures? Issues such as these have caused me to wonder to what extent impacts such as the relationships between some of the historical events stated above and recent effects of global modernity might have had on the indigenous practices explored in this study.

Historical Context of IKS

Historically, the concept of IKS has had negative connotations in academic arenas (Ntuli, 2001; Odora Hoppers 2001; Semali, 1999). Odora Hoppers (2001) argues that from the trajectory of the European project of domination and colonization towards the global south, the idea of the “other” emerged. With this “othering” came the view that IKS were “primitive” and “savage”. The trajectory of European expansion also brought with it the “empirical approach to science” (Odora Hoppers, 2002: 5), separating mind from matter, and leaving the concept of the world as a divided entity of binaries: an internal world of sensation and an external world of natural phenomena (Semali & Kincheloe, 1999: 26). With modernity, colonialism and later

imperialism, came the desire to conquer and civilize the indigenous peoples of the world, deeming them less than human and their systems of knowledge non-scientific and irrelevant (Semali & Kincheloe, 1999: 27). Science, as it came to be projected and understood, was a colonizing structure that controlled the flow of knowledge serving the European north.

Consequently, the complex knowledge systems of indigenous people were damaged, and knowledge production was limited to that of the European elite scientists, giving their “science” universal status. Soudien (2010) argues that the idea of there being biologically different races and the need to “civilize” them helped justify the European colonial mechanisms for the domination and subordination of the colonized. On the trajectory of Social Darwinism, “whiteness” became established as the “norm against which to read the rest of mankind” (Soudien, 2010: 5). At the end of the 19th century, a “European identity” was emerging in Europe (Soudien, 2010: 7), paralleling the “whiteness” that was becoming a signifier of order and rationality. This fuelled the scientific method conceptualized by Sir Francis Bacon: the “dominant-submissive relationship between scientist and nature...that was then reproduced in the colonial relations between European and indigene, in the power relations between universal and local knowledge” (Semali & Kincheloe, 1999: 30). In the context of South Africa, colonialism was driven by power from the metropole and its need for economic expansion and capital gain (Lalu, 2009: 103).

The impact of modernity and global development on indigenous peoples throughout the world has been profound, resulting in their cultures becoming fragmented against a backdrop of imperialism and capitalism, which created a “process of de-contextualization and restructuring of meaning” (Connell, 2007: 159). Like other indigenous communities across the globe, many cultures and communities in South Africa were devastated as a result of colonialism and its more recent expression of apartheid, “disconnecting them from their histories, their landscapes, their language, their social relations and their own ways of thinking” (Smith, 1999: 28).

Awareness of this historical trajectory helped ignite the quest for recognition of IKS, leading to the drafting and passing of a National Policy on IKS in 2004.

Recognizing Indigenous Knowledge Practices

The South African Indigenous Knowledge Systems Policy of 2004 called for an integration of IKS in multiple areas, including education, agriculture, health, the sciences, social sciences, law, languages, commerce and arts (Green, 2007: 130). With the intention of embracing a wide spectrum of IKS, emphasis has been placed on recognizing the many indigenous knowledges present within methods of farming, house-building, food preparation, healing modalities, technologies such as mining, and “indigenous geographies”, to name but a few, rather than focusing on the rather narrow view, held by some, of IKS being limited to traditional healing (Green, 2007: 130). There have been polarizing scholarly debates surrounding the IKS policy regarding the validity of indigenous knowledge within the realms of “science”, an unfortunate residue left by former President Mbeki’s decision to deny Antiretroviral Treatment (ART), in the name of traditional healing.

The plea for recognizing IKS is echoed by various scholars: Ntuli (2002) argues that knowledge is multifaceted and contextualized, and that the world should be viewed pluralistically, recognizing the interrelational character of everything that exists within it. Similarly, Ingold (2007) draws on the cyclical nature of the relational connections in the “flow” of life, as in “wayfaring”, where one continually moves along the “trail of life” interweaving with the trails of others, forming a “meshwork” that informs their practices. In Ingold’s words:

Wayfaring, I believe, is the most fundamental mode by which living beings, both human and non-human, inhabit the earth...and participate from within in the very process of the world’s continual coming into being and who, in laying a trail of life, contribute to its weave and texture. (Ingold, 2007: 81)

Connell (2007) emphasizes that knowledge from the South, including that which is indigenous, needs to be recognized and validated, arguing that “existing southern

theory points to a more engaged relationship between knowledge systems and foreshadows a mutual learning process on a planetary scale” (Connell, 2007: 222). Green argues that “indigenous knowledge movements want their different ways of organizing knowledge to be recognized because scientific knowledge practices discard so much of what they know to be useful” (Green, 2008: 146), whereas Viergever contends that the validation of indigenous knowledge is “critical for the survival of indigenous communities” (Viergever, 1999: 333).

In recognition of the multiplicity of knowledges, Paulin Hountondji (2012) warns that engaging in the competition of knowledge systems can bring two world-views on a collision path, causing a “cultural schizophrenia”. Instead, focus should be on the “integration of knowledge systems”, as suggested by Odora Hoppers (2002), meaning to engage in and have a relationship with, while at the same time applying a healthy critique of those knowledge systems. As Hountondji aptly puts it, “The main thing...is to create bridges, to re-create the unity of knowledge, or in simpler, deeper terms, the unity of the human being” (Hountondji, 1997: 15). Hountondji also argues that the idea of “traditional knowledge” portrays an inferior system of knowledge, stuck in time and space, and recommends the term “Endogenous Knowledge”, implying “an internal product drawn from a given cultural background” (Hountondji, 1997: 17) that is always changing and is dynamic.

In acknowledgment of the ongoing debates surrounding “indigenous knowledge” in this research, I will use the terms *indigenous knowledge practices* and *indigenous ways of knowing* in recognition that the knowledge is dynamic, valuable and crucial to the well-being and survival of the communities where it is produced and reproduced.

Health and Well-being

Concepts of Health and Well-being

Concepts of health and well-being stem from as far back as the times of Plato and Aristotle and have had various meanings. Plato's concept was that there had to be a balance between "hedonic" pleasure and pain, while Aristotle believed that well-being entailed something deeper and included the ability to flourish, to conduct a meaningful life and to be able to fulfil one's potential. This is also known as "eudemonic" well-being (Wiseman & Brasher, 2008: 355). While the New American Oxford Dictionary (2005) defines well-being as "the state of being comfortable, healthy or happy" (NOAD2, 2005) the relationships we cultivate within our social structures weigh heavily on our ability to maintain well-being, thus indicating that community well-being is a pre-condition for individual well-being (Wiseman & Brasher, 2008: 357).

In the World Health Organization (WHO) Millennium Ecosystem Assessment Report (2005), emphasis is placed on the link between the ecosystem and human well-being. It defines human health "as a state of complete physical, mental and social well-being" and human well-being as having access to "security; an adequate supply of basic materials for livelihood (e.g. food, shelter, clothing, energy, etc.); personal freedoms; good social relations; and physical health" (WHO, 2005: 12).

The Center for Disease Control and Prevention (CDC) has a similar view to the WHO (2005) report and suggests that well-being is contingent upon having positive emotions, having an absence of negative emotions such as anxiety or depression, having a positive outlook on life and feeling good. In addition, it states that research has shown that physical well-being, economic well-being, social well-being, emotional well-being, psychological well-being, life satisfaction, and being involved in engaging activities and work are all factors in possessing overall well-being (CDC, 2014: 3).

Biomedical terminology for health has focused on the body's ability to function and having an absence of disease. An example of an early definition of health is as follows: "a state characterized by anatomic, physiologic, and psychological integrity; ability to perform personally valued family, work, and community roles; ability to deal with physical, biologic, psychological, and social stress" (cited in Public Health Educator's Network, 2009).

Concepts of well-being vary within different religious and cultural traditions, but many of them have the common thread of viewing it as a number of interrelated components. Buddhism expresses well-being as being attained through engagement with compassion and creativity, while Islamic traditions call for living within God's will and following the teachings of the Qur'an (Wiseman & Brasher, 2008: 356). Whatever the tradition, concepts of well-being are ultimately informed by individual and group perceptions of self and the environment in which they live (Camfield, Crivello & Woodhead, 2008: 8).

Measuring Well-being

In the past, emphasis was placed on measuring well-being subjectively or objectively, while more recently, both types of indicators are utilized to measure well-being. Subjective measurement requires that individuals self-assess their personal well-being based on their satisfaction with their life, while objective measurement focuses on demographic indicators that affect an individual's life (Wiseman & Brasher, 2008: 356). The relationships between mental, physical and social health and well-being are being emphasized because indicators pointing to deficits in any one area can adversely affect another (Campion & Nurse, 2007: 25). Furthermore, influencing the state of well-being are "genetic factors, life circumstances and being involved in active pursuits and special interests" (Campion & Nurse, 2007: 26).

In this research, I do not focus so much on measuring the extent of well-being in people's lives, but more in terms of what practices are utilized to create and maintain well-being. Therefore I identify indicators that support aspects of mental, physical and social health and well-being, which include the ability to flourish, being able to lead a meaningful life, being happy and healthy, having access to security and being able to fulfil basic needs.

Indigenous Healing Practices

In order to maintain health and well-being, many African cultures seek healing via indigenous methods. According to the World Health Organization (WHO), approximately 80% of people in Africa use traditional medicines (WHO, 2008). The WHO advocates integrating traditional medicine into National Health Care systems in their member states, in collaboration with National Health Care Policies, in order to regulate the quality and safety of products, practices and practitioners. Furthermore, the WHO acknowledges traditional healing practices as being primary health care systems so that the knowledge and resources are preserved (WHO, 2008). In democratic South Africa, traditional healing has become noticeable in public discourse, with people of all backgrounds training to be healers or utilizing traditional healers as part of their health care regime (Thornton, 2009: 17).

In Benin, illness is said to be present in a person, either because of sorcery or because of spiritual attacks by one's ancestors. Spiritual attacks are experienced as a warning from the ancestors for "bad behaviour" or because they are feeling neglected, requiring that the ill person perform certain rituals or ceremonies (Ahyi, 1997: 223). Traditional models of healing are set in place to obscure realities and to prevent guilt or blame, hence to explain phenomena that are seemingly unexplainable, assistance in healing is accessed from the esoteric realm thus locating the cause outside of the patient. Focus is consequently not on the victim or patient but rather on the source of the ailment or cause.

If the instigators are spirits, they must be pacified. And if they happen to be mischievous, evil spirits, genies of a particular location, efforts

will be made to placate them, shift them or drive them out. The operative field of therapy in other words is located in some other being, some other environment, within the social group, or in the imaginary world. (Ahyi, 1997: 227)

In Xhosa culture, possessing the vital force *amandla* is essential for well-being, which encompasses physical health, a thriving family and healthy livestock (Jansen, 1973). To have good health one must have *impilo* (fullness of life) and be in balance with the cosmic vital force (Jansen, 1973: 38). Illness is believed to be caused by an imbalance in life, or a “diminution of the vital force” (Jansen, 1973: 38), the source of which is identified via the knowledge of the ancestors by a diviner (*igqirha*), also referred to as a traditional healer.

Thornton (2009) argues that the term “traditional healing” is inappropriate as it connotes a canon of ancient practices that continues to be unchanged and stuck in space and time. He states: “...the term ‘traditional healers’ is a misnomer if by ‘tradition’ we mean an unchanging conservation of past beliefs and practices, and by ‘healer’ someone who practices some version of physiological therapy aimed at organic disease” (Thornton, 2009: 17). Instead, he suggests that the sangoma (*izangoma*) tradition has developed over time and encompasses multiple cultures and languages, arguing that sangomas view themselves to be professionals, “with a distinct intellectual tradition, one that undergoes critique, modification, and change in the light of experiences and myriad influences” (Thornton, 2009: 17). *Izangoma* is an isiZulu term for diviner, whereas *igqirha* is an isiXhosa term. I heard both of these terms being used by people in the Mzingisi community.

In light of the WHO’s acknowledgment that traditional healing practices form part of the primary health care systems in the world and Thornton’s reference to the terminologies for “traditional healing” as indicating an unchanged, past set of practices, a dilemma arises as to how indigenous healing methods can best be termed. In this research, I have used the terms “diviner” and “traditional healer” interchangeably in recognition that the knowledge is outside the realm of “modern”

biomedicine, and that the knowledge is accessed esoterically through a process of divination from the ancestors. Furthermore, both terms were used in the community where this research was located.

Mndende refers to “African indigenous healing” in South Africa as “the healing of individuals by the ancestors”, involving the spiritual practice of an *igqirha* (diviner) and the “centrality” of *Camagu*,⁹ which holds ritual power and great importance when calling on the ancestors for their assistance (Mndende, 2006: 48). The healing approach of *amagqihra* is holistic and embraces the biological, psychological, spiritual and social aspects of the patient. Diagnosis of illness involves divination. *Amagqihra* are called to their work through their ancestors and undergo a comprehensive training period as an apprentice to a senior *igqirha* and under the guidance of their ancestors. An *umkhwetha* (initiate, training to become an *igqirha*) must pass through various stages of training before moving on to the next, culminating in the slaughtering of a cow in order to obtain the “tail brush”, known as *itshoba*, and graduating as an *igqirha* (Mndende, 2006: 54). Dold and Cocks (2012) explain that diviners aim to restore balance to their patient’s health and well-being through divination, seeking out the cause of his or her problem. Dold and Cocks (2012) contend that *amagqirha* can specialize as forest diviners (*igqirha lehlathi*) or river diviners (*igqirha lomlambo*), while Mndende states that diviners can also specialize in areas such as caves (*emiqolombeni*) or the sea (*elwagcwebeni*) (Mndende, 2006: 52). Unlike *amagqihra*, who are called to their practice by their ancestors, *amaxhwele* (herbalists) choose to specialize in Xhosa herbal medicine (*amayeza esixhosa*), which they supply to *amagqihra*. Xhosa medicine (*amayeza esiXhosa*) is made up of plants and/or animal products, and is utilized to treat a broad spectrum of illnesses and to protect against misfortunes such as witchcraft and bad luck (Dold & Cocks, 2012).

⁹ There is no exact English translation of the sacred term “Camagu”; however, it is uttered in rituals and has various meanings depending on the context e.g. “Be honored”; “Thank you”; “Let it be so” (Mndende, 2006: 11-12).

Impact of Colonialism on Traditional Healing Methods

Prior to colonial rule, traditional healing was the only form of healing available to the majority of people. When colonial governments and church missionaries arrived in Southern Africa, they quickly discouraged the use of traditional healing methods because they were not aware of the healing properties of traditional medicine, nor of the skills of the traditional healer. They deemed traditional healers to be “witch” doctors who “worshipped” their ancestors, and in so doing, believed that the traditional healers were steering people away from the government and mission hospitals that could better serve the people (Chavunduka, 1994). This is illustrated in a letter written by the missionary, Father Callaway, who was in South Africa in 1935:

It may be good to begin by telling you of the two recent happenings that have come upon us with quite a shock and forced us to realize, not only the tremendous hold that witchcraft still retains, but also that it has begun to take weapons from the Christian armoury and to use them with considerable effect...What is new to some of us is that some of our Christians themselves are being captured by witch-doctors, to be themselves trained for the profession. (Cited in Chavunduka, 1994: 5)

While this point of view is no longer completely the case, tensions still exist between traditional healers and more conservative Christians who Thornton claims “revile them as ‘primitive’, dirty and spiritually dangerous” (Thornton, 2009: 17).

South African Law and Indigenous Healing

In an attempt to formalize and regulate indigenous healing, the South African Government signed into law the Traditional Health Practitioners Act (Act No. 35 of 2004) in early 2005, specifying the requirements needed to practise as a traditional health practitioner (Thornton, 2009: 21). A “traditional health practice” is defined by the Act as:

[T]he performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine or traditional practice and which has as its object –

- a) the maintenance or restoration or prevention of a physical or mental health function; or
- b) the diagnosis, treatment, or prevention of a physical or mental illness; or
- c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
- d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth, and death. (Cited in Thornton, 2009: 21)

Thornton argues that the Act fails to recognize explicitly what it is that traditional healers do or their spiritual and religious affiliations, but instead implicitly implies that they are “lesser forms of medical practitioners” (Thornton, 2009: 21). Furthermore, the Act requires that all traditional healers must join the regulatory Council, which operates under the Department of Health, and have their knowledge practices controlled by a bureaucratic entity, indicating a reminder of the “legislative bullying” present during the apartheid era (Thornton, 2009: 22).

In this research, I investigate some of the tensions that exist between Christian belief systems, “modern” biomedical science, South African legislation and Xhosa traditional spirituality and methods of healing, and how they might influence the landscape of traditional healing knowledge and practices.

In the above sections, I reviewed the critical social theory of Anthony Giddens and emphasized agency and structure as a way to view reality. I then drew from the philosophy of Ubuntu and argued how Ubuntu animates a resistance to Cartesian dualisms such as mind-body, nature-culture and is integral to the development of personhood. I then reviewed literatures on indigenous knowledge and argued for a broader view of knowledge to one of multiple knowledges. This was followed by a review of literature about health and well-being.

In order to understand how the indigenous knowledge practices concerning well-being in this research are reproduced, learnt and relearnt, I draw from theories on informal and non-formal learning.

Reproducing Knowledge

Informal and Non-formal Learning

Walters (1998) argues that knowledge is socially constructed and often through informal or non-formal means. Furthermore, knowledge learned informally and non-formally has often been viewed as inferior, especially if it is knowledge pertaining to women, which often exists within dominating patriarchal systems. Walters contends that informal education is hard to define, but is “integral to the social fabric that produces and reproduces families, communities, and workplaces... [and] is unplanned, incidental learning” (Walters, 1998: 436). In the case of indigenous knowledge, informal education is often the vehicle by which it is reproduced. Non-formal education, however, often takes place through planned, short-term activities such as those pertaining to health or nutrition (Walters, 1998).

Situated Learning

Lave (1991) views learning as a social practice and posits that learning is developed through peripheral participation in communities of practice within the socio-cultural context of a given life-world. She argues that learning is not completely subjective or totally embedded within the social interactions of the participants, meaning that learning is an ongoing dimension of one’s lived life, which paves the way to forming an identity of knowledge-based skill within that community of practice. Lave explains:

This recommends a de-centered view of the locus of meaning and learning, in which learning is recognized as a social phenomenon constituted in the experienced, lived-in world, through legitimate peripheral participation in ongoing social practice; the process of changing knowledgeable skill is subsumed in processes of changing identity in and through membership in a community of practitioners; and mastery is an organizational, relational characteristic of communities of practice. (Lave, 1991: 64)

This understanding of how people learn differs from theories that promote binaries and the separation between individual cognitive processes such as internal processing, memory and problem solving, known as the “cognition plus view”, and language as an actor/actant in social activity that is constantly negotiated, known as

the “interpretive view”. Situated social practice and learning emphasizes the relational between agent and aspects within the world he or she engages in, namely, activity, meaning, cognition, learning and knowing (Lave, 1991: 67). Knowledge is produced and reproduced through the activity in which persons and/or the world are engaged. Within this activity are culturally embedded indicators that reveal different kinds of tacit knowledge, often developed informally, over time (Cooper, 2006).

In the context of this research, I ask how people acquire and reproduce knowledge within the rural village community, and specifically those tasks and/or skills for everyday living and cultivation of well-being.

Lave and Wenger (1991) develop their work to clarify confusion around the meaning of learning through apprenticeship, which had become synonymous with “situated learning”, and to further develop their own research on craft apprenticeship in West Africa. Their work led them to investigate and unpack the “relationship between ‘apprenticeship’ of speculation and historical forms of apprenticeship” (Lave & Wenger, 1991: 31), and to further interrogate the inseparable link between learning and social practice. They move from looking through an empirical lens to study forms of learning, particularly apprenticeship, to realizing that knowledge and learning are relational. In Lave and Wenger’s words:

It took on the proportions of a general theoretical perspective, the basis of claims about the relational character of knowledge and learning, about the negotiated character of meaning, and about the concerned (engaged-dilemma-driven) nature of learning activity for the people involved. That perspective meant that there is no activity that is not situated. (Lave & Wenger, 1991: 33)

Thus they came to understand learning to be a relationally and holistic process, a “generative social practice in the lived-in world” (Lave & Wenger, 1991: 35), meaning that the whole person is involved in the learning process.

Communities of Practice and Peripheral Participation

“Peripheral participation” is the term used by Lave to describe the reciprocal relationship between learner, as “newcomer”, and those practising and who have mastered skills, as “old-timers” within the community, creating a “two-way bridge between the knowledgeable skill and identity” (Lave, 1991: 68). Learners participate on the periphery of ongoing skill-based activity and absorb aspects of that skill base into their own life-world, until a point at which their knowledge and skills become masterful enough to give them an identity of being masters in that skill.

Lave (1991) refers to Jordan’s (1989) research with Yucatec Mayan midwives, where apprentice midwives spent much of their lives being peripheral participants in their elders’ life-work as midwives. As daughters or younger relatives of the midwives they had access to a broad base of knowledge present in the activity of midwifery: “Apprenticeship happens as a way of, and in the course of daily life” (Lave 1991: 70). Emphasis is placed on the learner utilizing a broad frame of reference within the context and culture of midwifery. As such, apprenticeship-learning activity pulls together knowledge from both past and present experiences as well as possible foreseeable experiences one might encounter in the future (pre-enacting). Thus one is participating in the process of becoming a master in the skill – becoming a possible self – developing a new or deepened identity.

Legitimate peripheral participation is the “central defining characteristic” of situated learning, which is learning within a community of practice. “Newcomers” are given the opportunity through engagement with and relation to “old-timers” to subsume knowledgeable skills, become part of a community of practice and over time, full participants in a “socio-cultural practice” (Lave & Wenger, 1991: 29). Through this collective process, practitioners’ identities are formed, being only partly formulated through a sense of one’s individual narrative. Thus participants recognize and validate the transformation of newcomers becoming old-timers,

which fosters a collectively lived identity (Lave, 1991: 74). This is emphasized in Daniel's quote of Lemke:

Our activity, our participation, our "cognition" is always bound up with, co-dependent with, the participation and activity of others, be they person, tools, symbols, processes or things. How we participate, what practices we come to engage in, is a function of the whole community ecology...As we participate, we change. Our identity-in-practice develops, for we are no longer autonomous Persons in this model, but Persons-in-Activity. (Lemke, 1997, cited in Daniels, 2001: 97)

Daniels (2001) refers to Lemke's notion of social semiotics, which expands on Lave and Wenger's model of peripheral participation, and suggests that one draws from an accessible and relevant frame of reference to gain meaning beyond the immediate. Thus, learning can be developed "in and across activities and communities of practice" (Daniels, 2001: 74). In this research, I consider how knowledge is transformed from an apprenticeship level to a master level through the process of peripheral participation in the everyday activities that require specific skill sets (Lave 1991), and how the knowledge remains as a continuum of "shared histories" between generations (Cooper, 2005).

Cultural Historical Activity Theory

How might one begin to make sense of how indigenous ways of knowing can be clarified and then melded with European approaches? In what follows, I look at Activity Theory as a way of, firstly, locating how people in their traditional settings constitute meaning in activity and, secondly, to begin to suggest how Hountondji's ideal of bringing together different knowledge forms might be realized.

The origins of Activity Theory have been traced to the 18th and 19th centuries during the period of Hegel and Kant, where notions about the role of humans centred on the historical and developmental (Togo, nd: 1). It was then developed in the former Soviet Union in the early 1900s by psychologists Vygotsky, Leontiev and Luria, because of the need to transcend dualisms such as mind-body, subject-object,

internal-external, within the field of psychology. It was recognized that human learning was realized through a system of activity that was influenced by the social-cultural-historical contexts within which the learning took place (Holzman, 2006). Vygotsky's theory of activity has been described as a breakthrough in the field of psychology, because it questioned the nature of being human while embedded within the social, historical and cultural context (Peim, 2009). His theory, which was considered to be socio-historical, migrated from Soviet Russia to the West and became known as a "socio-cultural" approach (Daniels, 2001; Hardman, 2008). For Holzman, Activity Theory is a "non-dualistic approach to understanding and transforming human life that takes dialectical human activity as its ontology" (Holzman, 2006: 6).

At the heart of Activity Theory debates is the notion that all knowledge is situated and is experienced socially in relation to human activity, which is historically and culturally based. Vygotsky's world-view was said to be dialectical, emphasizing the relational, which is necessary for knowledge construction, and he believed that binaries in thought were actually connected as opposite parts of a continuous whole (Daniels, 2001). CHAT therefore allows one to take Giddens' ideas of structuration to another level and interrogate more deeply the multiple complexities present in social reproduction.

It has become widely known that there are three generations of Activity Theory. The first generation reflects Vygotsky's original socio-historical theory represented in a triangle, where the subject or individual's actions are mediated by tools and oriented towards an object. These tools or cultural artefacts, which can be simultaneously conceptual or material, thus transform the environment in which the individual/s live, bringing from the past aspects that help to mediate the present (Cole, 1995: 32). This is represented in a triangle (see Figure1) in which "the vertex is a mediating artifact and the remaining points at the base are the subject and object" (Cole, 1995: 52). Hardman (2008) explains: "the natural relationships represented at the base of the triangle are subsumed by the cultural relationships

represented at the apex of the triangle” (Hardman, 2008: 4). This brought about new ways of thinking regarding understanding the human psyche. Individuals were no longer regarded as separate from their cultural backgrounds and society was understood as being dependent on the agency of individuals who utilize and produce artefacts (Engeström, 2001).

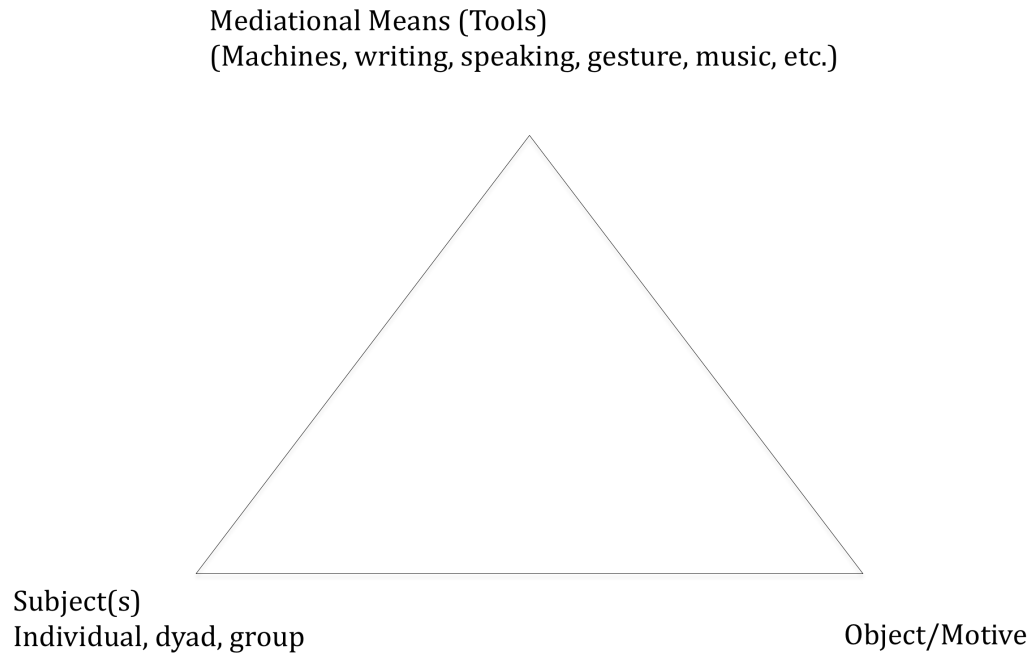


Figure 1: First Generation Activity Theory Model

Vygotsky’s theory was further developed by Leontiev who, in inaugurating the second phase of theory building, emphasized that human activity is always motivated by the object, which can be material or an idea, and is oriented towards a goal or outcome. Leontiev also demonstrated a hierarchical structure of human activity (Figure 2), illustrating the difference between individual actions and a collective activity (Engeström, 2001), and emphasizing that different objects determine different activities, which are directed towards goals (Leontiev, 1978).

Leontiev explains:

The shifting and developing object of an activity is related to a motive, which drives it. Individual or group action is driven by a conscious goal. Although actions are aroused by the motive of the activity, they

seem to be directed towards a goal...the one and the same action can serve different activities (Daniels, 2001: 86).

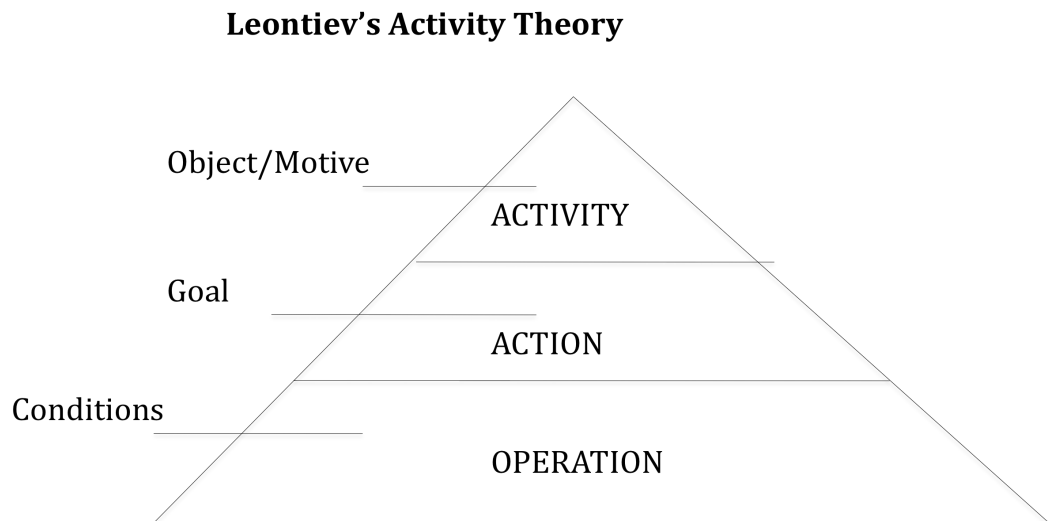


Figure 2: Second Generation Activity Theory

Leontiev also emphasized that an activity system cannot be analyzed without taking into account the relationships within and between the activities in the system.

These are the relations that conceal transformations that occur as activity develops. Objects themselves can become stimuli, goals, or tools only in a system of human activity; deprived of their connections within this system they lose their existence as stimuli, goals or tools (Leontiev, 1978: 67).

In other words, examining the internal relationships of the activity system can reveal hidden aspects not immediately visible to the naked eye.

Engeström developed the theory further so that one could analyze activity systems at the “macro level of the collective and the community” rather than focusing on the micro level of an individual (Daniels, 2001: 89). Engeström’s activity triangle has the additional features of rules and values, community, and division of labour (see Figure 3). The elements of the activity system include: subjects, who are participants

of the activity, and tools, which are the resources that subjects use to obtain the object or the goal. Rules can be informal or formal regulations that subjects need to follow while engaging in the activity. The community is the group that subjects belong to, and the division of labour is the shared responsibilities determined by the community. Any component of an activity system can bring about tension in the subject's effort to attain the object. The outcomes are the consequences that the subject faces as a result of the activity, and can encourage or hinder the subject to participate in future activities (Yamagata-Lynch, Pamental & Smaldino, 2007: 5). These elements are depicted in Figure 3:

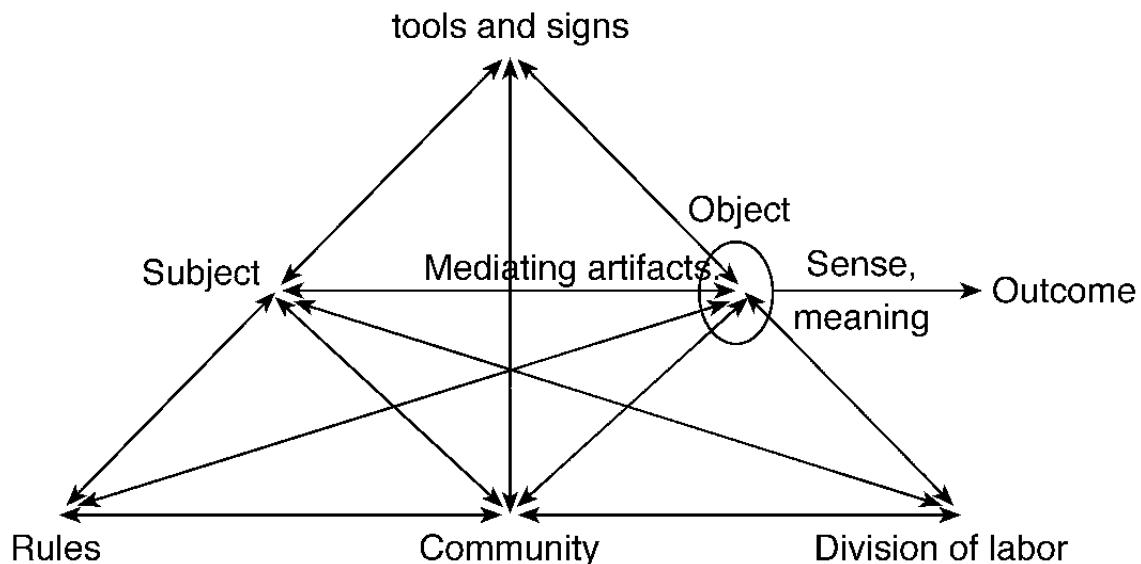


Figure 3: Third Generation Activity Theory (Engeström, 2001).

Engeström's development of the activity system in the third phase of development of the theory includes the addition of an oval, which helps to show that "the object-oriented actions are always, explicitly or implicitly, characterized by ambiguity, surprise, interpretation, sense-making, and potential for change" (Engeström, 2001: 134). This expanded depiction of an activity system highlights interrelations

between the subject and the community and brings into focus what Il'enkov emphasized as the importance of the contradictions that surfaced within the activity system, which are potential catalysts for change and transformation (Engeström, 2001). Critiques of Engeström's third generation activity system, particularly Michael Cole's, found that it lacked sensitivity towards cultural diversity and aspects relating to different traditions and world-views. Engeström then initiated the first depiction of a third generation activity system that took into account multiple world-views and interrelations between multiple activity systems. Engeström however, realized that this is an ongoing project between activity theorists and could be developed further (Engeström, 2001).

Wertsch (1985) contends that thought processes and social interactions can be understood through the tools and signs that mediate them (Wertsch, 1985: 13), and that cultural tools mediate action as well as the power dynamics relative to those tools (Daniels, 2001). Activity is mediated through artefacts or tools such as orality and language, and social, cultural and historical contexts to create meaning, understanding and ultimately, knowing. Thus ways of knowing are articulated through the participation in activity. This social process, according to Cole (1995), is often informed or influenced by cultural norms and expectations, "a process of shaping and being shaped", and leads to different levels of identity formation (Daniels, 2001: 36).

Vygotsky emphasizes a world full of objects that "are culturally constructed, historical in origin and social in content" (Daniels: 2001: 43). In the context of this research being located in a rural area that was disenfranchised by the apartheid regime, individual and collective life-worlds are connected to and are derivatives of the past and present, into the future. They cannot be separated because the impact and aftermath of the apartheid era is still affecting people's lives. Activities are therefore woven with the threads of the past and present, with a corollary into the future.

Conclusion: The Conceptual and Analytical Framework

The task of developing a conceptual and analytical framework for this research that could adequately elucidate the complexities surrounding continuity and changes in indigenous knowledge practices regarding health and well-being, required drawing from and bringing into conversation three sociological theories, that of Giddens' critical theory, the African philosophy and sociology of Ubuntu, and the Vygotskian socio-cultural, psychology-based Cultural Historical Activity Theory (CHAT).

The conceptual framework underpinning this research was drawn from Giddens' critical theory because it helps to explain the complexities within social structures and society. Additionally, it illustrates the dynamic relation between social structure and human agency, and the choices made surrounding individual and collective production and reproduction of knowledge. To complement Giddens' theory, I drew from the African philosophy and sociology of Ubuntu because it serves as a set of principles from which to understand human activity, behaviour and knowledge practices within the auspices of a community structure, which has cultural histories embedded within it. Ubuntu is holistic and transcends dualisms and so offers a way to make meaning from and gain a better understanding about the continuum of cultural histories and knowledge practices and development of personhood in relation to the social structure of the community being researched.

Drawing from literature that highlights some of the debates surrounding indigenous knowledge was essential in deepening my understanding of where indigenous knowledge is positioned historically and politically in the discourse about knowledge. This literature also broadened my awareness of how the indigenous knowledge practices being explored are critical to the identity of individuals and the identity of the community. Furthermore, this literature emphasizes that indigenous knowledge practices are dynamic and that practices are influenced by the ongoing evolution of modernity.

Theories of informal and non-formal learning showed that learning and the production and reproduction of knowledge are contextually situated. Theories of informal and non-formal learning explained how the contexts of everyday life are often the places where learning is experienced, especially for women. Situated learning theories went further to explain how knowledge is produced and reproduced socially within communities of practice, where the learner gains mastery over time.

Finally, Cultural Historical Activity Theory strengthened the conceptual framework by providing a way beyond Giddens' critical theory, to uncover the hidden aspects and meaning within activities in a social structure, and making clear the complexities surrounding the dissemination of multiple knowledges or ways of knowing in that social structure.

CHAPTER THREE

METHODOLOGY AND RESEARCH DESIGN

This chapter outlines the overall methodological approach to this study. It explains the rationale for an ethnographic case study design and how I went about collecting and analyzing data. It concludes with discussion of the validity of the study, ethical considerations and the limitations of the study.

Broad Methodological Approach

In Chapter One, it was stated that the concern of this research was to explore, analyze and conceptualize the indigenous knowledge practices concerning health and well-being held by different generations of women and how they are reproduced cross-generationally in a rural isiXhosa-speaking community. Additionally, how the relationship between concepts of self, personhood and the philosophy of Ubuntu informs personal agency and well-being was addressed. My own personal history and background led me to this research with the goal of bringing recognition to the knowledge practices being explored and to offer a new interpretation in academic arenas about how such knowledge should be viewed. It is the explorative nature of this research that influenced my choice of methodology, which required broad qualitative methods.

Critical Qualitative Research

Guided by Giddens' theory of structuration, the research is concerned with the nature of social structures, power, culture and human agency (Carspecken, 1996: 3). As this research is qualitative in its approach, it is broad in scope, detailed, descriptive and relies on multiple interactive methods (Toma, 2006). This approach adopts holistic, empirical, interpretive methods and is conducted in a natural setting that centres on work in the field (Toma, 2006: 407). I chose an interdisciplinary study that draws from both critical and constructivist theories and assumes that reality is influenced

and shaped by social, political, cultural, economic, ethnic and gender values, and that the construction of meaning is locally contextualized (Toma, 2006: 409). It is therefore holistic in approach and assumes that knowledge production cannot be separated from its socio-cultural or historical context.

Heuristic-Hermeneutic Research

Heuristic Approach

Heuristic research engages the researcher in six phases of research: initial engagement, immersion in the topic or question, incubation, illumination, explication and culmination of the research (Kahakalau, 2004: 23). Through this engagement, “the deepest currents of meaning and knowledge take place within the individual through one’s sense and perceptions, beliefs and judgments” (Moustakas, 1990: 15).

This research adopts a heuristic, interpretive approach with the aim of discovering fundamental meaning from the human life experiences present in the study. Specifically, my aim is to understand and draw meaning from the multiple aspects within the life experiences of the rural women and their indigenous knowledge practices that relate to their health and well-being. This approach is aligned with indigenous ways of knowing, and involves the researcher on a personal level (Kahakalau, 2004: 21). Utilizing heuristics also enables the community and participants to help guide the research in a spiralling form. This meant that I learned with and from the community over the 18-month period that I was living and working there (Moustakas, 1990).

It was my intention to be able to engage in this research while maintaining a relationship of integrity with the community and participants. This required me to form relationships that were “face-to-face” (Green, 2005: 97), ensuring a pluralistic, active participation of both myself as researcher and the participants being researched. This is also described as co-engaged learning (O’Donaghue, personal

communication 2010, April 14), and is in alignment with what Mkabela describes as the “Afro-centric approach to research” (Mkabela, 2005: 184). This approach requires forming a partnership with the research participants and their community thus ensuring participants “active involvement” and collaboration. The Afro-centric approach was important for me, both because I identify as an African woman and because I wanted to be respectful of the cultural context of community. My volunteer work in the community helped me to form collaborative partnerships with participants.

Hermeneutic Approach

Hermeneutics is the art of interpreting knowledge (Ramberg & Gjesdal, 2005), and aids in the understanding of knowledge. In Gadamer’s terms it allows one to be able to hear various interpretations and perspectives on an issue, and learn from it as another possible meaning (Stevenson, 2000). Adopting a hermeneutic approach in research can facilitate the researcher in understanding from the perspective of the participants and the social structure within which they live their lives (O’Reilly, 2009). By adopting a hermeneutic approach in my research I would be able to collect my data and interpret meaning from the various perspectives present within the community, or beyond the knowing to the meaning (Meyer, 2006).

Meyer illustrates the application of hermeneutics in what she terms the “Triangulation of Meaning”, which asks one to “see the whole in all parts...to view reality in an outside, inside and a transpatial way” (Meyer, 2006: 263). Meyer borrows the metaphor of “triangulation” from wilderness education, which teaches one to use three points to fix a location on a topographical map. To do this, one only has to “locate two geographical distinctions on land and, with the use of a compass and pencil, the third and final spot – your location – can be found” (Meyer, 2006: 265). It is from within these metaphoric terms of “triangulating our way to meaning” through the body, mind and spirit, that one is able to access deeper meaning from the discoveries found within the research, through engaging fully

with body: objective/empirical knowing, mind: conscious subjectivity, and spirit: recognition and engagement with deeper realities (Meyer, 2006: 265). Meyer further emphasizes the extension of empirical knowing into deeper thought and reflection, with a final connection with the higher self, stating: “other ways of knowing must be introduced if we are to evolve into a more enlightened society” (Meyer, 2006: 265).

Research Design

This section outlines my reasons for choosing an ethnographic case study approach, the rationale for using this approach, and the steps followed in the research process.

A Case Study Approach

The aim of this study is to gather an in-depth perspective of how women in a rural setting reproduce indigenous knowledge practices related to their health and well-being. A case study approach best meets this purpose because it allows the researcher to draw meaning from purposeful human interactions within a complex social structure “bounded by time and space” (Toma, 2006). A case study enables the researcher to study the “particularity and complexity...coming to understand its activity within important circumstances” (Gray, 2003: 68).

A case study approach is helpful in that it can help generate useable knowledge and can support the development of theories through questioning how things work, and it can expose the “multi-layered complexity” of the subject being studied (Gray, 2003: 68). The strength in using a case study approach is that one can “paint” an accurate picture of the subject and context of the study; however, the picture can be limited in that it usually cannot be easily generalized to other contexts (Gray, 2003).

The Ethnographic Approach

I chose an ethnographic approach because it embraces a holistic and phenomenological method of gathering data, which allows the researcher to

interpret events and participants' situations from different perspectives and in several ways. An ethnographic approach allows the researcher to interpret meaning from the emic or participants' perspectives, and also from an etic or researcher's perspective (Fetterman, 1998). An emic perspective enables engagement with the participants' way of life and gains access to multiple realities. An etic, or external/outsider perspective allows a deepened analysis by adding an outsider's external view into the interpretation. A good ethnography has a non-judgmental orientation and includes both emic and etic perspectives to elucidate meaning, which presents the "essence of a culture" (Fetterman, 1998: 24).

Data Collection

Planning the Fieldwork

The aims of this research were to explore and gain a deep understanding of the indigenous knowledge practices concerning the health and well-being of isiXhosa-speaking women in a rural Eastern Cape community. Prior to conducting this research, I spent a number of weeks exploring some rural areas of the Eastern Cape trying to figure out exactly what it was I wanted to research and where would be a suitable area to do so. Initially, I met with some relatives in East London who had various contacts in the Eastern Cape. I then made some initial contacts with an NGO serving urban rural communities near King William's Town, and also attended meetings with a contact at Rhodes University in Grahamstown and a contact at Walter Sisulu University in Mthatha. All these meetings were valuable and helped me to clarify for myself that I was interested in "life skills" – the everyday indigenous practices that enabled health and well-being. My concern was with how to gain access to a suitable community within the time frame that I was obligated to honour, and how I would go about collecting data for this study. Another concern was with how I would be perceived by members of the community, as an outsider and yet also as someone who has "Xhosa" roots. My worry was that even though I had Xhosa heritage, I was born and bred outside of South Africa and did not speak isiXhosa.

Gaining Access to a Rural Community

I was conscious of the fact that because I was going to be researching an indigenous and rural community, I wanted to be able to participate in community life as much as possible and be able to serve the community in some way. I was cognisant of some of the issues faced by indigenous populations who, having been viewed as the “other”, have also experienced being researched as “objects” of fascination (Breidlid, 2013). I did not want to be a “typical” researcher who went into a community to extract information and then left with a treasure chest of “cultural booty” (Mkabela, 2005). I therefore decided to visit some NGOs that supported educational community projects in some rural communities in the hope that I could volunteer and share some of my skills, and in time gain access to participants through my work.

A Serendipitous Encounter

While staying in a campsite, I met some university students who had been doing some volunteer work in a community close by, and who recommended that I contact the Director of the NGO there as there were several projects they thought I might be interested in. When I contacted the NGO Director, she explained that they had been looking for a volunteer to support their educational projects and were very eager for me to meet with them. I arranged to attend an initial meeting and visited the community in November of 2010. I agreed to volunteer for the NGO in an educational capacity from the February to December of the following year, which was the initial estimated time frame for this research. In exchange, I was provided with free accommodation.

The Site

Having selected a community in which to conduct my fieldwork, I realized that there were potentially many sites that were suitable for collecting data. My data collection needed to focus on women and the indigenous knowledge practices that enabled their well-being, how that knowledge was reproduced cross-generationally, and

how the philosophy of Ubuntu influenced their agency and personhood. I felt that there were several sites that would serve my needs, but I started with the centre of the community where the school and hospital were, and some of the immediate surrounding areas.

The day after my arrival, I was taken to the educational site where I would be working. It just so happened that it was the second-year birthday of the school and there was going to be a celebration party with juice and cake. I was introduced to the teacher, her assistant, parents and friends, and of course, the children. It was no surprise that I was coming to work there. As I entered the room I noticed the welcome sign that had been hand-coloured by the children hanging on the wall, and was immediately honoured with a chant in unison of “Welcome Teacher Yolisa” from the children and adults. It was then announced that I would be helping the school in various capacities and that I was also there to conduct research. So my foot was well and truly in the door, and it would just be a matter of time before I would enter more deeply into the community as I got to know people and they got to know me.

I drew from the notion that an ethnographer works with people in their natural setting where he/she would witness “people and their behavior...in all its wonder and complexity” (Fetterman, 1998: 33). Therefore my data collection would need to involve several methods and techniques to ensure validity.

Collecting Data

My research was ethnographical, and so required a variety of methods for data collection. The methods I needed to use would be observations, informal and semi-formal face-to-face interactions, writing of field notes, semi-structured interviews, and co-engaged learning processes such as focus groups.

Data collection took place over an 18-month period from March 2011 until September of 2012, with a break in the middle and at the end of the year. The breaks allowed me to connect back with the university and my supervisors and to see my family.

Observations

According to the *Chicago School* researchers make sense of the world being studied through participating in everyday experiences and viewing the social structure through the interactions between the actors in the setting (O'Reilly, 2009: 150). Integral to effective fieldwork is "participant observation", which requires the researcher to immerse him/herself in the culture and participate in the lives of the people under study while observing and recording information about them (Fetterman, 1998: 34). In order to study "knowledge", or what people know, one has to study what people do with their knowledge, which can be accomplished through "participant observation". A "participant observer" can observe in two ways: either as an "observing participant" who is an insider and records aspects of life going on around him/her, or as a "participating observer" who is an outsider that participates in some aspects of life and records what is going on around him/her (Bernard, 2006: 347). For the purposes of this study, I was mostly a "participating observer" – an outsider participating in aspects of life and recording what was going on around me; but there were times when I was a "complete observer", observing from a distance, with little interaction or participation.

Some strengths of participant observation are that it opens up possibilities for collecting all kinds of data and reduces the possibility of "reactivity" where people change their behaviour because of your presence (Bernard, 2006). Furthermore, participant observation allows the researcher to gain some intuitive understanding about what is going on in a culture (Bernard, 2006: 355). Participant observation also seemed to be the best way for me to enter aspects of participants' lives so that I

could experience some of their knowledge practices and gain better understanding from their perspective.

Participant Observation

I began with a “big-net” approach, where I spent time in the community mixing and mingling with many different people in various sites and settings. This afforded me a “wide-angled view of events” (Fetterman, 1998: 32), before I narrowed down my focus and picked specific sites from which to collect data. In addition to “just being around”, and feeling things out about the people and my surroundings (Gray, 2003: 83), I decided that a great way to observe what was going on around me, was to run through the village in the early mornings. So I began getting up around 5.45 a.m., just as dawn was breaking, donning my running gear and taking to the road that wound its way through the village until it ended about two kilometres away. This not only gave me a picture of how life was lived and who was doing what in the early mornings, it also gave me an opportunity to be seen by the locals and to have small interactions along the way. I continued to do this about three times per week throughout the duration of my fieldwork, which helped me to build a “primary record” of events, which were recorded in a number of journals (Carspecken, 1996: 44). I made more formal observations at special events such as at a marriage ceremony and a cleansing ceremony and when visiting traditional healers. I also did more formal observations when I went on ward rounds, observed a Caesarean-section birth and tubal ligation at the hospital, at school events and community events, and when I went on home visits with several NGO outreach workers.

Recording Observations

Observations were recorded in a number of ways. The primary record consisted of what Geertz terms “thick” detailed and descriptive notes of events, daily activities and various social interactions with and between the participants (Carspecken, 1996). These included the relational ties between participants and the various activities participants were part of within the community. It also included common

daily practices such as those I observed while running, for example: women carrying water or wood, preparing fires for cooking, or doing their washing by the river or water hole. I also recorded observations of what the landscape looked like, details about the homesteads I passed, people I greeted, the kinds of livestock present and changes that I noticed from one day to another or from one week to the next. Observations of events such as rituals and ceremonies, traditional healing divination, doctors doing ward rounds at the hospital, operations in the operating theatre, outreach workers on home visits, school events, large community events and my personal daily interactions with various people each day were also recorded. These notes were handwritten most late afternoons or evenings, and were later typed up on the computer as a data set. After a few months, however, I began writing straight onto the computer.

Field Notes

Writing field notes required recording less detailed notes and reflections, on a daily basis, of different aspects of the day's observations and events. These sometimes consisted of short notes or "jottings" (Bernard, 2006) written in the moment on scraps of paper or in a small notebook that I carried around with me. During sessions when I was a "complete observer", such as following a doctor on rounds at the hospital, I recorded notes in my field journal of as many aspects as I could as we went from ward to ward. Additionally, I also kept personal notes that reflected on my own feelings about the fieldwork, the community and my various roles, as well as my own biases and misconceptions. These also served as a source of data.

During the early period of my fieldwork, I also began thinking about and formulating questions around health and well-being, relating to indicators that had been gathered through my observations and interactions. I then began designing tentative interview schedules. A sample of my field notes is presented below:

We reached the second homestead after crossing the river and walking up to the ridge, through the forest. It seems like no one is home initially, but then we are told to go inside the hut to wait. Inside the hut there are two beds, a kitchen cabinet with some

utensils and crockery on it. Then the moms arrive and their respective partners and it seems like grandparents as well. There are two men who come in and sit on the bed and the women sit on the other side. I sit on a bench and watch. The mentor mother takes out her paperwork and the scales and begins the weighing procedure.

Interviews

I identified key informants to interview to inquire more deeply about an event or subject matter and to deepen my understanding of some of the cultural aspects embedded within practices, or the significance of the practices. Interviews also enabled me to inquire specifically about knowledge reproduction, especially across generations. Interviews were informal or semi-structured and were conducted throughout the fieldwork period, with the first one taking place after about three months of my being in the community. Informal conversations and semi-structured interviews were conducted to gather more detailed and focused information about informants' daily lives and individual and collective practices related to health and well-being. The informal conversations took place regularly during ongoing participant observation and were generally free flowing. The semi-structured interviews were guided by a set of general questions that required some "fixed responses" but also included thematic and free-flowing responses (O'Reilly, 2009: 126).

Selecting Interview Participants

After a few weeks working in the community, I talked more openly about doing research with my co-workers and other NGO volunteers, with the hope that I would get leads about people who might be open to being interviewed. After several months of living and working in the community I was able to begin identifying specific sites and participants. I started by identifying possible homesteads and multigenerational families living in homesteads where there were elderly, middle-aged and young women and/or teenage girls. I also began identifying key informants who held significant positions in the community such as traditional healers, outreach workers and hospital staff. To get a broader sense of how knowledge concepts and practices are learned, my hope was to also find teenagers

who were either attending or not attending school. Additional informants were doctors from the hospital, the pastor and his wife, NGO volunteers and outreach workers, my translators and various women I got to know in the village.

Participants in the interviews were primarily isiXhosa-speaking women living in homesteads in the central community and surrounding areas. Twenty-one participants were selected, mostly consisting of differently aged women. They were selected in various ways; for example: some of the women I had come to know quite well through my volunteer work were my friends, some worked with the NGOs as outreach workers or as HIV counsellors, and some I had come to know through people I had met or had worked with in the community, or who had become acquaintances through my daily encounters.

Some of the informants were selected after I had attended a ritual or ceremony in order to gain further insight into the meaning of them. Some informants were chosen specifically because they seemed to be the best candidates, such as the traditional healers, who were accessible and who I had built a certain amount of rapport with. Six of the women were “mother and daughter” dyads; however, the daughters were interviewed separately from their mothers. I interviewed the three middle-aged women who had become my friends together in a group because I wanted to gather rich data about their experiences relating to marriage, childbirth and childrearing. They all knew each other well and my hope was that by listening to each other’s stories it would help to spark each other’s memories, and in that way provide rich accounts of their experiences. I also conducted one focus group with six NGO outreach workers who conducted home visits to monitor new mothers, their babies and young children. To gain access to a participant for an interview, I asked them directly or through a translator.

Overall, I conducted seventeen individual interviews, one group interview and one focus group. Interviews were with seven young women under the age of thirty-five, two elderly women, three middle-aged women (as a group, and one on her own),

two traditional healers, whom I interviewed twice, and two men. The focus group consisted of six women.

Although I interviewed two men to gain some insight about employment and everyday life from a man's perspective, for the purposes of this thesis, I have mostly included data from the interviews I conducted with the women. Excerpts from these interviews are included throughout the analytical chapters to add to the richness of the data being analyzed and to show the depth of meaning.

Language Medium and Interviews

For ethnographic research, it is strongly recommended that the researcher becomes adept at speaking the language of the participants, as inferences can best be made by tapping into participants' own reflections and self-revelations (Bernard, 2006). The risk of using a translator is that information may not always be accurate, as was revealed in critiques of anthropologist Margaret Mead's work in Samoa (Bernard, 2006). "Fluency in the local language doesn't just improve your rapport; it increases the probability that people will tell you about sensitive things", said an experienced fieldworker, Naroll, in 1962 (Bernard, 2006: 361). While I had built rapport with most of my interviewees, there were instances when I wished that I had been fluent in the language. The majority of the interviews were conducted in isiXhosa, through a translator. Four interviews were conducted in English because the participants were fluent and finding a suitable translator proved to be difficult at times.

All interviews were recorded and notes were taken throughout the interview. The interviews that were conducted in isiXhosa were sent to a translator who taught isiXhosa at the University of Cape Town. The translator transcribed all the interviews verbatim, but included her own translation beneath the translation of my village interpreter. This was to show any discrepancies and to clarify some of the meanings. A sample of this can be found in Appendix B.

Interview Questions

A collection of questions was created to use during the semi-structured interviews to determine what the notions of health and well-being were and how Ubuntu and personhood were expressed within the community. The questions were broad and flexible, for example:

- Tell me about Umngcamo.
- What is it for or what is its purpose?

(Further examples of interview questions can be found in Appendix C.)

Ethical Considerations

Informed Consent

All interview participants gave verbal agreements to be interviewed when the initial date and time were established. Informed consent was obtained from all interview participants before each interview began. At the beginning of each interview session, I read the contents of the Informed Consent form to the participant, and these were translated sentence by sentence by my translator and any questions about the interview or the form were clarified; then the form was signed by the participant.

Anonymity

All names have been omitted from this thesis and fictitious names have been assigned to participants in the observation and interview data. To protect the community and all informants in this research, a fictitious name has also been given to the village and NGO names and website names have been omitted. Additionally, permission was obtained from two sources to omit the name of the community in the reference titles in order to protect the community and participants.

ANALYSIS OF DATA

As described in Chapter One, the concern of this research was the exploration of knowledge practices and how those practices were produced and reproduced. The analysis for this research adopts both inductive and deductive methods and is descriptive and interpretative.

Early Analysis

My analysis began while I was still doing my fieldwork and texts were being created as I wrote up my descriptive notes and field notes. While writing up field notes I began to see that there were many potential themes and categories into which I could begin organizing my data, so I decided to initially follow the Grounded Theory Approach for organizing and interpreting my data.

Grounded Theory

Grounded theory is a way of developing theory while doing research. The theory evolves while the researcher is actively collecting and analyzing data (Strauss & Corbin, 1994). Grounded theory is often utilized for analyzing ethnographic data and seemed to fit my research well. This process required reading through all the text I had accumulated from my data, and identifying themes, categories and concepts and linking them back to the conceptual framework (Bernard, 2006) discussed in Chapter Two. As I read through my field notes and interview transcripts, I looked for incidences of knowledge practices, knowledge reproduction, indicators of Ubuntu, types of agency, and how participants viewed personhood.

Coding

Themes started to emerge from the text, which I made note of through the process of coding (Bernard, 2006). I began by highlighting important sections of text and then colour-coding them according to themes. In the margins, I started writing down abbreviations for themes and sub-themes. After this stage, I created tables of sub-themes or categories that were linked to the themes. Having visual cues helped

me to stay on task and to keep my analysis linked to the concerns in the research question. Themes that began to emerge were:

- Everyday knowledge
- Specialized knowledge
- Indigenous health practices
- Biomedicine
- Formal education
- Informal education
- Homesteads
- Rituals and ceremonies
- Evidence of Ubuntu
- Childrearing and socialization

Below is an example of a table of sub-themes and categories linked to themes:

Sub-themes and categories linked to themes:

Land Environment	Community	Homesteads Family	Ubuntu	Formal & Informal Education	Bio-medicine	Specialized Knowledge
Homesteads Agriculture Gardens Firewood Water Sources Homebuilding Ubuntu	Education Training Church Rituals Celebrations Infrastructure Projects Library Shebeens Jobs Transport	Homebuilding Decorating Water tanks Firewood Cooking Belongings Utensils Laundry Ceremony/Rituals Preventive measures against bad luck and witchcraft	Socialization Community Personhood Rituals Ceremonies Marriage Homesteads Land Ancestors	Schools Childcare Parenting Nutrition NGOs	Hospital care HIV/AIDS ARVs Child-birth	Traditional healers Hospital NGO outreach Hospital Clinics

Once themes and categories were established, I could go back through the text and look for forms of social control, hierarchies established within the social structure, and contradictions and irregularities such as practices or behaviours that were not aligned with some of what seemed to be norms in the society (Bernard, 2006). Additionally, Bernard suggests looking for “evidence of social conflicts, cultural

contradictions and informal methods of social control” (Bernard, 2006: 494). Examples of these were found in the challenges to well-being such as:

- Beliefs
- Weather/thunderstorms
- Witchcraft/sorcery
- Wrath of the ancestors
- Poverty
- Access to water
- HIV/AIDS/TB

I then took large pieces of “butcher” paper and wrote headings across them and stuck them on the walls around my room. As I worked my way through texts and interview transcripts, I would write the colour-coded notes onto post-its and stick them under the headings on the butcher paper. In this way I could establish aspects of practices that were linked to subthemes, under different headings – a form of cross-referencing or “memoing” (Bernard, 2006). For example see below:

Traditional healers

Igqirha/izangoma
Ancestors
Divination
“Xhosa” medicine
Herbs
Grinding stones
Protective/cleansing rituals
Charms
Special sacred tools

Marriage

Negotiations
Lobola
Ancestors
Traditional healer
Protective/cleansing ritual
Slaughtering
Bridal party---gifts

Computer-coding

I had discussed the possibility of using a computer-coding programme with my supervisors, to assist me in my analysis, but ran into challenges finding software that was compatible with my Mac computer. I discovered one programme called “Dedoose” and embarked on a 30-day free trial to see if this would make the analysis process less daunting. I decided that after watching several Webinars, it

would be easier for me to continue on the path I was already on rather than try and learn a new system.

Second-Phase Analysis using Cultural Historical Activity Theory (CHAT)

In order to delve further into my data and find deeper meaning within the practices I had observed, and from the interviewees that spoke about some of those practices, I began using CHAT.

As explained in Chapter Two, CHAT was developed from the psychology of Vygotsky, Leontiev and Luria, who recognized that learning developed through human activity and was influenced by the socio-cultural-historical contexts where the learning was taking place. This is important for the purposes of looking at indigenous knowledge practices, that is, culturally, historically and contextually evolved knowledge. Furthermore, individuals could no longer be regarded as being separate from their cultural backgrounds, and society was understood as being dependent on the agency of individuals who utilize and produce artefacts (Engeström, 2001). Engeström considers artefacts “as integral and inseparable components of human functioning” (Daniels, 2002: 88), which are used to mediate their activities.

Engeström posits that human activity is a “collective, systemic formation that has a complex mediational structure” (cited in Daniels, 2001: 86). An activity system creates and is created by actions but is not only made up of actions, which are short lived across time and space. Rather, activity systems “evolve over lengthy periods of socio-historical time often taking the form of institutions and organizations” (Daniels, 2001: 86). Furthermore, they are established through “constant negotiation, orchestration and struggle between different goals and perspectives of its participants. The object and motive of a collective activity are something like a constantly evolving mosaic, a pattern that is never fully completed” (Engeström, 1999, cited in Daniels, 2001: 90).

In relation to analyzing this research more deeply, utilizing CHAT enabled me to look at the social structure and knowledge practices in relation to their activity systems. In other words, by identifying the different activity systems that emerged from the texts of my data collection, I was able to then look at all the components that go into making up that social structure, such as the multiple perspectives and power relations that are inherent within and between them. Furthermore, I was then able to come to a better understanding of the multi-layered spectrum of continuity and change in the reproduction of the knowledge.

There are five principals that are articulated within CHAT, as suggested by Engeström, which are summarized as follows:

1. The prime unit of analysis is a collective, artefact-mediated and object oriented activity system seen in its network relations to other activity systems. Activity systems realize and reproduce themselves by generating actions and operations.
2. An activity system is always a community of multiple points of view, traditions and interests of active agents, i.e. subjects. The division of labour in an activity creates different positions for the participants; the participants carry their own diverse histories and the activity system itself carries multiple layers and strands of history engraved in its artefacts, rules and conventions, which it multiplies in networks of interacting activity systems and can be a source of innovation or a source of trouble.
3. Activity systems take shape and get transformed over lengthy periods of time. Their problems and potentials can only be understood against their own history, and the history needs to be studied from the standpoint of its location.
4. Contradictions are sources of change and development, but are not the same as problems or conflicts. They are historically accumulating structural tensions within and between activity systems.

5. There is a possibility of expansive transformation within an activity system. An expansive transformation is accomplished when the object and the motive of the activity are re-conceptualized to embrace a radically wider horizon of possibilities than in the previous mode of activity. (Engeström 2001: 136)

I used the above elements of CHAT to help reduce my data to attain focus. For example, when analyzing indigenous practices, I realized that they were carried out according to gendered roles and divisions of labour, and that those roles were often related to cultural-historical hierarchies and patriarchal influences within the homestead. However, due to tensions and or contradictions, some women were also resisting some of the divisions of labour and the patriarchal.

An example of an activity system is represented in the triangle illustrated below:

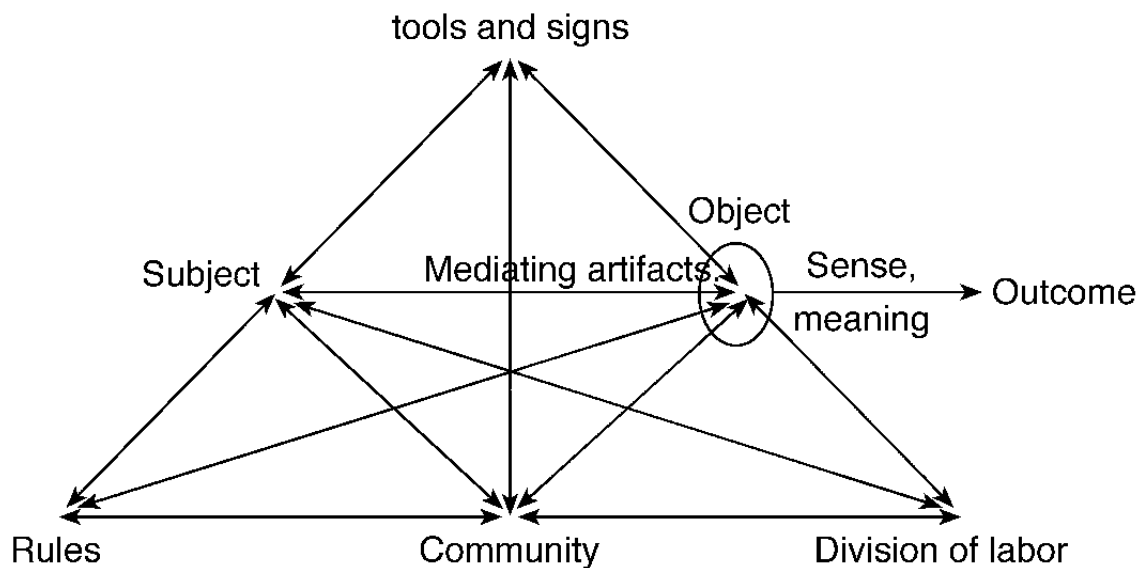


Figure 4. Source: Engeström 2001

When considering Engeström’s activity system, the triangle is three-dimensional and more like a pyramid or tetrahedron. As such it represents the many layers (from

apex to base) of the socio-historical, which could include deeper and hidden aspects present within a social system such as historical trauma or intergenerational issues.

Methods of Validating Data

Validity in qualitative research is measured by the “accuracy of the picture presented of the subject and context of the study” (Gray, 2003: 71). To ensure validity, research should represent the subject authentically, and consist of an in-depth, context-rich and plausible account of what took place. Additionally, researchers should use multiple sources of data and link their findings to prior or emerging theory (Toma, 2006).

Carspecken emphasizes that validity is dependent on the data and field records being representative of what occurred, the analysis of data being done correctly, and the conceptual basis of the analytical techniques used being sound (Carspecken, 1996: 57). Furthermore, researchers should spend a prolonged period of time in the field, use low inference vocabulary, have peers check for possible biases, and use member checks to authenticate what took place (Carspecken, 1996: 89).

To meet the validity requirements and portray as accurate a picture as possible, data was used from multiple sources such as observations, field notes, informal and semi-formal interactions and interviews. Fieldwork and data collection took place over a prolonged period of time and was written into a context-rich, in-depth account of what took place. Data analysis was done following qualitative research methods and was linked to the conceptual and analytical framework and research question. While I cannot claim that this research represents absolute “truth”, it is my intention that my findings authentically represent the participants and as Carspecken says, “point toward the truth” (Carspecken, 1996: 57).

Challenges to This Research

There are several challenges to this research. Firstly, because the research is a case study, data collection was limited to one region of the Eastern Cape and represents one rural community, so that it cannot be generalized empirically, although I hope to enable theoretical generalization. Secondly, as an ethnographic study, this research was conducted over a relatively short period of time and can only claim to touch the surface of the knowledge practices being investigated; however, within the time frame, I was able to gather rich sources of data. Thirdly, using a translator during interviews can enhance the risk for inaccuracies in meaning and understanding. Nevertheless, it is my hope that I was able to minimize the possibility of inaccuracies by having all the interviews translated by an isiXhosa language speaker and teacher who is also a professional translator.

Locating Myself as a Researcher

In all research, the background of the researcher plays an important role in the context of the research itself. I am a middle-aged African woman of Xhosa and English descent, who grew up in England and Zambia, and has lived in the United States and Hawai'i for most of my adult life. As a descendent of a South African political exile, I did not grow up within my Xhosa culture, or learn to speak isiXhosa as a child. My desire to embark on this research was deeply personal and gave me the opportunity to live and work within a Xhosa cultural context and help fill the "cultural gap" that has been ever-present in my life. As an outsider, I was fortunate to be welcomed into the community where this research was conducted and to be accepted for who I am as a bi-cultural "global citizen" who has roots in the Eastern Cape. Although my position was one of privilege and this research was developed from a Western-influenced academic context, my global background and citizenship also gave me the advantage of being able to adapt well to the community's socio-cultural context, and my "outsider" status allowed me to be more objective, which makes my findings more valid.

Organization of Findings

My findings are presented in the following three chapters, from a broad context to a more focused and specific context. In Chapter Four, I present findings that illustrate the indigenous knowledge practices within the ecology of the homestead and that are essential to everyday living and well-being. In Chapter Five, I present findings regarding health practices that women use to cultivate and maintain their well-being. In Chapter Six, I present findings of practices regarding childrearing and socialization. Lastly, Chapter Seven presents an in-depth analysis to elucidate deeper meaning from some of the stories that emerged within the three “findings” chapters.

CHAPTER FOUR

THE ECOLOGY OF A HOMESTEAD

Introduction

This chapter is the first of three chapters that describe and analyze different knowledge practices related to health and well-being. The focus of this chapter is the indigenous knowledge practices found within the ecology of the homestead, beginning with a detailed description of some of the physical and spiritual aspects of the homestead and their role in creating and maintaining well-being. I then present a descriptive and analytical narrative of the indigenous knowledge practices and skills that are necessary for building and maintaining a homestead and how knowledge and skills are reproduced. This is followed by a section with a detailed description of the ways in which knowledge practices relating to marriage and the joining of two homesteads are a significant component within the ecology of the homestead. This is followed by an analysis of the relationship between gender, knowledge and the patriarchal. Descriptions will be drawn from fieldwork observations, field notes, informal conversations and interactions, and semi-structured interviews as well as written texts.

The ecology of a homestead encompasses family members – the living and the non-living (those who have passed away), the land and livestock, as well as all the relationships between them. Good relations between the living and non-living ensure a healthy homestead (Mndende, 2006). Historically, a homestead (*umzi*) was established by an extended family made up of the family head and his wife/wives, children and ageing parents, the huts of married sons and their families, and unmarried daughters. The huts were built facing eastwards, in a semi-circle around the cattle kraal. If the family head had more than one wife, each wife would have a household of up to three huts, a main hut for living and cooking, a second hut for children and visitors, and a third as a storeroom (Charnock, 2006: 49).



A homestead

Following is an example of observations made and recorded in my field notes:

As I walk through the village, I marvel at the many homesteads on either side of the road – round rondavels made of mud brick and painted in sea greens and blues, salmon pinks and tan; a palette of colour against the landscape. Now and then, there is a “flat” – a rectangular house with a tin roof, built in-between two huts or on its own, some with a water tank attached. Some homes are decorated with patterns down the edge or on the front, like the one I call the “palace”. It has a gate, barking dogs, cattle and sheep, and is decorated with black spades and clubs like those in a pack of cards.

In the Mzingisi area, a homestead comprises several round huts with thatched roofs and/or rectangular buildings (known as flats) that have corrugated tin roofs. The huts are organized in a social order, with one or two huts for living space, a hut for storage, one or two kraals where livestock are kept, and a garden for growing staples like mealies (maize), pumpkin, spinach and cabbage. There are usually various members of a family living in a homestead, although the owner normally

serves as the head of the household (Kepe, 2002). The huts and flats are painted various colours for decorative purposes, and these apparently do not hold any symbolic meaning, although some people believe that homes should not be painted too brightly as it will “blind” the ancestors when they come to visit, or offend them if they are too dark. Thatched roofs, I am told by my translator, are decorated with a rubber tyre filled with soil and plants, and pieces of white shell, to prevent owls from landing on them, as owls are believed to be bad omens and sent by witches. The tyre placed at the apex of the roof also serves as a lightning conductor, which according to Dold and Cocks (2012), would also get filled with a succulent plant (haworthia or gasteria) that protects against witchcraft, which comes in the form of lightning (Dold & Cocks, 2012: 55).

When one goes inside a main hut, there is usually a bed or two on either side of the hut, and in the centre against the back wall, a set of cabinets stacked with plastic buckets for storing food, cooking pots, a tea kettle, plates, cups, glasses and eating utensils. There is also usually at least one cast-iron *potjie* pot (three-legged cooking pot) and paraffin stove. Flats are often made into a sitting room or bedroom and contain a lounge suite, or bedroom furniture.

Sacred Spaces

The homestead is considered to be sacred because it is the place where family members gather, hold rituals and ceremonies, and are buried. It is also where the kraal is situated. The “great hut” (*indlu enkulu*) is the designated hut or special place for religious gatherings and rituals, and is divided into two sections by a fireplace (*iziko*), which delineates a place for women on the right and for men on the left (Mndende, nd: 8).

The Kraal (*Ubuhlanti*)

In every homestead there is at least one kraal (*ubuhlanti*), a semi-circular or square enclosure made of wooden poles and branches, or a wall of stones and a gate at the

entrance. A small kraal is used for sheep or goats, and a larger one for cattle. The cattle kraal is considered to be a sacred space and is divided in the following way:

1. The entrance (*exhantini*) is believed to be where the ancestors are present and is highly charged with their energy. This is where the elders will address the ancestors when there is a problem related to ancestors, and to ask for their help. If a ritual performance is required, the elderly first stop at the *exhantini* and speak to the ancestors, explaining the purpose of the ritual before entering the kraal (Mdende, nd: 9).
2. The kraal is divided from the entrance into two sections, the right side representing the men of the clan and the left side representing the men of the community. Men sit according to seniority, which is usually determined by birth date and the number of years of adulthood since initiation (*Izilimela*). The side opposite the entrance (*exhantini*), at the back of the kraal, is known as *Umthonyama*. This is where *abafana*, the young initiated males, sit. Mdende emphasizes: "Because *abafana* differ in status they are also defined according to seniority prescribed by their months of initiation. The youngest will therefore sit at the back" (Mdende, nd: 8-9).

Dold and Cocks (2012) contend that some homesteads may have more than one kraal so that livestock can be separated, but only the main kraal is used for rituals. Households without livestock create a sacred "byre" as a place to have rituals and communicate with the ancestors (Dold & Cocks 2012: 66). Kraals are only accessible to males, and the custom of *ukhlonipa*¹⁰ prohibits women from entering, unless they are immediate family members (Dold & Cocks, 2012).

¹⁰ The custom of *hlonipha* is practised as a way of showing respect and generally applies to women in their in-laws' homesteads (Mdende, 2006: 36).



A cattle kraal

When walking through the village, it becomes apparent that many homesteads have cattle horns attached to the fence at the entrance of a kraal. My interpreter tells me that this signifies that a ritual sacrifice has taken place and that a revered male elder may be buried close by. Dold and Cocks (2012) explain that in rural areas it is common for the father of the home to be buried beneath the wall of the kraal. In order for male elders to gain vital power (*amandla*) and to live a long life, a ritual is usually conducted at the kraal. Soga (1931) confirms that skulls and horns of slaughtered or sacrificed cattle are placed on the gatepost to the entrance of the kraal, and also explains that if someone is ill and a traditional healer is brought to officiate over a sacrifice offered to the ancestors on behalf of the ill person, then the skull and horns are placed above the doorway of the hut. My interpreter speaks very seriously and with intensity as he points to the kraal and explains the following:

Those horns of a cow are for an important man before. The new horns are put here. If the cow does not cry out at the time of slaughter, yoh! The ancestors are not happy, and the ceremony must be stopped. Something else needs to be done.

Dold and Cocks (2012) explain that cattle used for sacrifices are said to be chosen by the ancestors and are usually revealed through a dream. When the time comes for slaughtering, the chosen animal is taken into the kraal and tethered to a pole, usually standing in the centre. Once the animal is lying on its side, the attending elder passes the blade of the sacred assegai under and over its limbs and then prods it until it lets out a cry. “The bellow is taken as a sign that the offering is accepted by the ancestors and...is finally stabbed in the heart” (Dold & Cocks, 2012: 75). Mndende (2006) explains that while the sacred assegai is passed over the animal it is being cleansed for the ancestors. Furthermore, she emphasizes that the cry of the animal is not due to any pain as a result of being stabbed, but that the cry occurs before the animal is slaughtered. If the cow does not cry out before it is slaughtered, then the ceremony is not sanctioned by the ancestors and must be stopped. Something else needs to be done, or rectified, before it can proceed (Mndende, 2006: 11).

The Presence of Ancestors

Ancestors (*izinyanya*) are said to be present in a homestead as the non-living members of the family, and are deeply connected to those who are living. Although they have passed away, according to Mndende, ancestors are thought to be “sleeping” and are only “partially physically separated” from the rest of the living members of the family (Mndende, nd: 6). Aspects of life within a homestead may frequently revolve around the caring for, entertaining and appeasement of the ancestors. Offerings and sacrifices to the ancestors are common in many households, even if Christianity is practised. Sacrifices of cattle or goats mark rites of passage, or are made in honour of one’s ancestors, in hopes of maintaining good relationships with them, and in return, receiving protection from them. Ancestors also provide guidance, healing and moral teaching, and are a means to maintaining

unity between members of the family or clan (Mndende, 2006: 5). Ancestors are believed to occupy the kraal (*ubuhlanti*), and are said to “reside and ‘brood’ over their descendants with a benevolent eye” (Dold & Cocks, 2012: 66).

Building and Maintaining a Homestead

Constructing a Hut

It can take several months or even years to complete the building of a hut, depending on the extent of monetary resources within the family on the homestead. While bricks can be made from the earth near the homestead, other building materials have to be purchased. Much of the building labour is done by men, which can mean waiting for male family members to return from migrant workplaces, and/or for enough money to be saved to pay someone to do the building.

Making Bricks

Making bricks is labour intensive and so it may take several months to make enough to build a hut. While out walking along the roadside, I notice there are several homesteads dotted along a sparse and open landscape, with several areas of land being utilized for making bricks. Newly made bricks are laid side by side in neat rows and left out in the sun to dry. Each brick-making area has a large 200-litre blue container standing near the bricks – usually filled with water or a mixture of mud, cow-dung and grass, the main ingredients used for making the bricks. It takes several weeks or months before they will be dry enough to use for building, depending on the weather. Most people say that bricks like these last up to ten years, but will then need to be replaced.

Bricks are usually made during the winter months when the rains have left and the ground is dry. I observed bricks being made on several homesteads, often with several women working together collectively. Making them takes several weeks, and evidence of brick production can be seen across the terrain. The earth needed for making bricks, plastering walls and surfacing floors, is dug by women and is

collected from within the homestead boundaries, or from common grasslands, with permission from the sub-headman (Goldman & Petrie, 2010). This is then mixed with cow dung, grass and water before being moulded into a wooden frame and pressed out as brick. While visiting a nearby community, I helped a woman make a few bricks. I had to dip my hands in the blue container, scoop out a good dollop of the cow-dung-grass-mud mixture and put it in the mould. The consistency needed to be just right so that the mixture would stay in the mould and form a brick. It felt warm and slightly slimy as it squished between my fingers. I had to repeat this process a couple of times before there was enough to press out a brick. Once the mould had enough mixture in it, I flattened the top to make it smooth, then carefully pushed out the shape onto the grass beneath it. *Voilà!* There was my first brick.



Homemade bricks for building a hut

The stones needed for building foundations or for grinding maize are usually collected from grassland areas or dams by men, and transported in wheelbarrows, or by mules or donkeys pulling a sleigh (Goldman & Petrie, 2010: 14).



Donkeys carrying bags of stones

When thatching needs to be done, men who specialize in this skill are hired. When I stood inside a hut being prepared for thatching and looked up at the rafters, I could see they were perfectly spread apart, in a circular order around a central pole. Bunches of thatch grass will be placed on the rafters and secured with a long braided rope made of a special grass (*umsinginizane*). The grass needed for thatching is collected by women and tied into small bundles, but the grass required for securing the thatch on the roof is woven or braided into rope by men. The floors of the hut are made with cow dung and are maintained by adding a new layer each spring, which is always done by women.



Inside a thatched roof

Maintaining a Homestead

From my observations, maintaining a homestead is a collective responsibility, with tasks being divided up amongst family members. These tasks are often done according to gender. Women are usually responsible for taking care of the family's daily needs, which include collecting water, collecting wood and making fires, preparing food and cooking, heating water for bathing, washing clothes, taking care of chickens and feeding small livestock, providing childcare and caring for the elderly. Men are mostly responsible for the care of cattle and sheep, maintaining the kraal, slaughtering livestock, mending and maintaining fences, thatching and fixing roofs, ploughing and preparing the ground for sowing, and other menial tasks. Some men also hunt, and/or fish, in order to provide food for the family or to sell as a means of income. Some of the observations I made and recorded in my field notes

show the various types of tasks undertaken each day to maintain the smooth running of a homestead:

In the early mornings just as the sun is rising, the day has already begun for many of the women and girls, before they go off to school. They are already preparing for the day: breaking up firewood and preparing the morning fire, feeding chickens, collecting water from the river and carrying it to their homes in large buckets on their heads. Young boys and men usually carry the water containers in a wheel-barrow. It is usually a woman that is seen preparing firewood for the morning fire, bent over, breaking the branches with her foot, and piling them on top of one another in a bundle. When the sun is further up in the sky, women are doing their washing in plastic tubs, at the edge of a water hole or by the river, then laying it out on the grass and surrounding bushes where it is left to dry. On weekends, the whole family might be out working together in the early morning soon after dawn, preparing the ground for sowing seeds. Sometimes the men have a mule attached to a plough, or they are using hoes and spades.

Most homesteads keep some form of livestock. Most commonly there are chickens, raised both for eggs and for their meat, which are often seen for sale at the village market each month. Chickens are mostly free-range and roam around the homestead, including inside people's huts. They peck around the yard and are generally fed vegetable scraps and dried maize. Eggs are laid under bushes where hens brood or keep their young, and mornings begin with a cacophony of roosters greeting the dawn's light. Families also keep pigs. However, in 2010, according to some of the doctors at the hospital, the Department of Health put out a ban against keeping pigs in an attempt to reduce the incidents of illness caused by people eating pigs that have consumed human waste – the normal diet for free-roaming pigs. Over the period of this research, the pig population seemed to be steadily increasing. Wealthier families generally have a herd of sheep or goats, and some cattle. Some families even keep flocks of geese or turkeys, which, I was told, are raised for eating. Cattle are usually raised for *lobola* and important ceremonies such as weddings and funerals. Goats and sheep are kept for both *lobola* and rituals, or sold as a means of income. Herds are often seen roaming through the village, on the main road and on common grazing land, and can be identified by their owner's branding or mark. In the late afternoons and evenings, there are flocks of sheep or small herds of cattle being driven back to their owner's land by a young boy or herdsman.



Sheep grazing on common land

Family livestock hold significant value, not only in rituals and ceremonies, where they act as channels for communication between the living and non-living, but also as symbols of wealth and personhood. Grazing land (*idlelo*) is common land around and between homesteads shared by livestock owners to graze their household livestock – sheep, goats and cattle (Goldman & Petrie, 2010: 16), hence the need for strong fencing to keep them out of homestead gardens and fields. Young boys learn to care for animals at an early age, and children attending primary school or even preschool are seen helping older boys to take care of small herds of cattle and sheep, such as is illustrated in the following excerpt from my field notes:

It is an early morning when I notice a young boy of about nine years old, standing in a maize field with a herd of cattle. It is obviously his task to watch and care for his family's herd for the day. There are seven cows of various shades of grey and brown, typical of the Nguni cattle found in this area. On my return, he has been joined by five

other boys, all sitting against the fence chatting to one another, while the cattle graze on the maize husks left over from the recent harvest.

This area is the home of people who historically have prided themselves as cattle herders (Jansen, 1973), and cattle were a means of wealth and stability. At the time of the historical “cattle killing” tragedy, in 1856, clans from this area moved to a so-called “no-man’s-land” and refused to kill their cattle. However, they tragically lost tens of thousands of cattle to the rinderpest disease in 1897, and the East Coast Fever in 1910 (Jansen, 1973: 13). Although there seems to be an abundance of animals around this community, not all families can afford to raise them, or have the capacity to keep and take care of them. Thus for rituals and rites of passage such as boys’ and girls’ initiation ceremonies, or funerals, families are dependent on collective resources provided by extended family members.



A herd of cattle

Accessing Water

Water is valued greatly and having access to a clean supply is an ongoing issue for many living in the immediate and surrounding area. Most people do not have piped water in their homes and have to collect it from the nearest streams and springs. More affluent homesteads have the convenience of a rainwater tank, which provides drinking water most of the year – although in winter they are prone to run dry. While rainwater tanks are becoming more common, they provide water for drinking purposes only. This means that women and girls still bear the burden of collecting water from the river or streams for everything else: washing, cooking and cleaning. If a homestead does not have a rainwater tank, drinking water is collected from a nearby spring or stream, rather than from the river, because the water is thought to be cleaner. (It is quite common to see men washing their cars or their taxis right in the river, both in the Mzingisi area and in other areas in the Eastern Cape.) When I accompany Lindiwe to collect water from the spring just below the hospital, it is clear that she prefers collecting her water upstream from the car-washing place. It is a small area of water and just above it is a tap, which has water dripping from it. I ask her if she will use it, and she replies that she will not, because it is usually broken:

“No sisi, we are going to scoop the water.” She squats down and carefully “parts” the water with a tin cup, clearing the surface, which has leaves floating on top. She smiles at me and adds, “The good, sweet water is underneath.” She scoops and fills her bucket, then I fill mine.

Water is normally collected early in the morning shortly after dawn, in 25-litre buckets that women carry on their heads. One woman told me that collecting water from the river is usually done in small groups, for safety, but individuals go alone to the spring by the road. Young teenage girls are sent to fetch water, in small groups, before they go to school in the morning, while boys and men are seen using a wheelbarrow or carrying the water in 5-litre containers – one in each hand. Carrying water is a skill that is often learned from a fairly young age, and on one occasion, I saw a young girl of about four years old quite distraught and crying loudly because she had dropped her bucket, spilling the water on the ground. She

had obviously been accompanying her sister, who had a large bucket on her head. When I asked Lindiwe how long it took her to learn, she said that it was not very long and quite easy, and that she had learned as a teenager. I also noticed that it took some skill to part the water without stirring up the sediment at the bottom, which she could only have learned through practice. Water is usually heated on an open fire or paraffin stove, in an enamel kettle for making tea or coffee, or in a big pot for bathing purposes. The washing of clothes is almost always done with cold water, and many women wash clothes next to a stream or pond.



Lindiwe scooping water from the spring

The Importance of Firewood

Firewood (*iinkuni*) is an essential commodity as it is used for cooking, heating water, and for heating in winter. Wood is collected from wooded areas mostly by women, who master their skills and take great pride in building a woodpile outside their huts in a designated area of the homestead. Many woodpiles are in full view of passers-by on the road or the main pathway between homesteads. After gathering

the firewood, women place it in piles and tie it together before it is lifted onto their heads to carry home. Often groups of women are seen carrying firewood back to their homes early in the morning or later in the afternoon, when it is cooler. On one occasion, I counted 27 women standing in the distance with wood on their heads. I did not approach them, as it seemed like an organized activity, and when I inquired about it later, one of the translators told me that it had to do with safety measures because it wasn't always safe to go out to the forest, and that women had been "held up" for money or a cell phone.



Mother and daughter carrying firewood

The woodpile (*igoqo*) signifies that females are present on the homestead and is therefore considered to be more than just a "woodpile" (Goldman & Petrie, 2010). The *igoqo* is of great value and also signifies that a married woman on the homestead is a hard worker. As such, the *igoqo* acts as a status symbol. It is also said to be a place of peace, where married women gather, or a more formally designated

area for members of other clans to meet for rituals and ceremonies. In the past, for example, it was where placentas or stillborn babies were buried after birth. The *igoqo* is also where a mother would announce the arrival and gender of her new baby, as *ngumntu wasegoqweni* (child of the *igoqo*, or girl) or *ngumntu wasebuhlanti* (child of the byre, or boy) (Dold & Cocks, 2012: 80). While much of the cooking is done with collected firewood, dried cow dung, known as *amalongwe*, is also used.



An *igoqo* (woodpile)

Gardening and Agriculture

As mentioned earlier, most homesteads have a vegetable garden to supplement the traditional main diet of maize and beans. Generally, gardens produce maize, beans, spinach and pumpkins, cabbage, beetroot and tomatoes. Excess vegetables are sold for extra income, either at the monthly market or to passers-by. It is always possible to buy spinach from a family in the area or get cabbages from the pastor's garden.

Some adventurous gardeners might also have carrots, potatoes and/or sweet potatoes. At a minimum, it is common for people to grow maize, beans and pumpkins, because maize and beans are a staple, and pumpkin leaves cooked together with mealie-meal is a favourite food. The soil for gardening is usually prepared by men and/or adolescent boys, using a plough and mule, or pair of oxen, although small gardens are often taken care of and prepared by women. Following, I describe some of my observations:

There are clear signs that it is spring. When I go out in the early mornings, I see men with their mules ploughing in the fields. This morning, I pass three young adolescent boys with a mule and plough. One boy is holding the plough, and the other two are walking beside the mule. The mules wear shades over their eyes, which I assume are to keep them focused on the job at hand and to stop them from being suddenly startled. Some of the fields are already showing the fruits of hard work: young mealie stalks about a quarter of a metre high stand vibrantly green against the dark brown of the soil. Pumpkin leaves are also present, planted between the mealies. On the edge of the field, I see there is spinach and huge cabbages ready to eat, reminding me of the days when there is a truck laden with cabbages leaving the community and heading towards town.

Traditionally, maize has been the staple diet, and here the maize is of several varieties. My friend tells me that if the maize is multicoloured, it is called *mcwabe*. When maize is cooked as whole kernels with beans, it is called *mboti*, and as broken pieces with beans, it is called *mngcuso*.

After the women harvest, maize is generally stored in piles on reed mats or in reed baskets inside a storage hut, where they are kept dry for use throughout the year. Maize is an important crop not only as a staple food source, but also because it is used for making ceremonial beer called *umqombothi*.

Preparing *Umqombothi*

Xhosa beer (*umqombothi*) is brewed to mark most rituals and ceremonies and to appease and entertain the ancestors. On one occasion, I visited a homestead where several families were preparing *umqombothi*, collectively, to welcome newly circumcised men returning home after their initiation period in seclusion. Beer has

to be made to offer to the ancestors and to welcome the new men in their new stage of life. The following describes my visit to the homestead:

We drove to the end of the road, then took the dirt track a little way before parking. There were three huts on this homestead. We entered the largest hut, where an elderly woman and a young man (possibly her son) greeted us. My interpreter explained who I was and why we were there. The woman was petite, and was wearing a traditional skirt and head wrap, and wore a blanket wrapped around her waist. (It was particularly windy outside.) There were also three children, under the age of five; one was sleeping on the bed. The woman told us to sit down and then immediately passed me her bowl of food and told me to eat. It was a bowl of samp and beans. I took a few spoonfuls and thanked her, then gave her back the bowl. She also gave me a glass of water, which was crystal clear and tasted sweet. The hut had three beds in it (one double) and a kitchen cabinet, with kitchen/household goods – pots/tubs of food, etc. – on it. There were four big blue plastic vats for brewing beer in the right-hand corner. One was filled with freshly ground maize and was waiting for the next step of cooking it. On the floor were four grinding stones (amatyeokusila). There were also hens and chicks pecking around inside, eating pieces of maize off the floor. After a while, it was time to look at the stages of making the beer.

There are five stages in preparing *umqombothi*. This is how making *umqombothi* was explained to me:

1. Maize is ground with grinding stones known as *amatyeokusila*.
2. The ground maize is put into a big plastic vat with some water to make it moist, where it is left until it has germinated.
3. Traditional yeast (*inkoduso*) is added, and it is left until it has fermented.
4. Then it is cooked and left for several hours to cool down.
5. It is then strained through a woven sieve.

The first sample is put into a 5-litre container, to be offered to the ancestors the night before the men return. Once the ancestors have had their share, the rest can be shared with the family and community.



Stones for grinding maize (*Amatyeokusila*)



Barrels for making *umqombothi*

The beer-making is a communal project between several families who all provide a share of maize that they have grown themselves. The collective welcoming back of the “new men” is to bear witness and to acknowledge that they went through the rite of circumcision and are in a new stage of life as men. It is also a collective celebration, as Mndende (2006) explains:

On reaching the village, the initiate, in the company of men, is received with great jubilation, singing, dancing and ululating. At the kraal the

initiate is taken either into a hut or to the cattle kraal where men have gathered to admonish him. The initiate's new status as a man is stressed – the duties, which he has to assume and behaviour expected of him towards other people. Some of the admonitions from the elderly include respect of the elderly, conforming to all customs, fulfilling all the rites and ceremonies of their forbears, and exercising a spirit of liberality towards their neighbours and friends. They are told to abandon all childish behaviours. The relationship with the spiritual world is stressed as they are told never to anger their ancestors. They must live a morally good life and by so doing they will be rewarded by the ancestors. (Mndende, 2006: 26)

Circumcision is not only a rite of passage but an educational period, where initiates are formally prepared for adult roles in life, regarding the military, politics, religion, legal issues, marriage and sex, during their seclusion in initiation school (Mndende, 2006: 23).

Seed Security

Most women collect seeds from their annual harvest of beans, maize and pumpkins. The beans and maize are heirloom strains that have been passed down from one generation of women to another. A friend and I visited two homesteads to look at the many varieties of heirloom beans that were growing there. We were greeted by a big smile from the mother of the house and taken out to the fields. Most of the beans had been harvested and were drying on reed mats, but some were still on the vine. The ones on the vine were of interest because there were several varieties growing at the same time, although there was only one variety per vine. The beans drying on the mats were an assortment of colours and sizes: black, maroon, maroon speckled with white, white speckled with brown and maroon, marbled, yellow and orange – it was quite remarkable. Later, we went to her neighbour's homestead and saw a similar situation with many varieties drying on reed mats and some still on the vine. The neighbour said that her seeds were old and that they had originally come from her mother. The field was quite large and was able to produce several hundred kilos in a year. The owner estimated there were 50 to 70 kilos drying on the reed mats, and said that she would keep seeds for next year's planting and

continue to keep beans as seeds each year, as they were better than the ones in the shop. When we asked about the colours, she said that she couldn't see so well, so couldn't really tell us which ones were best.

Seeds are usually harvested seasonally from vegetable gardens, so that there is a ready supply each year. Faseka, a gardening expert in the community, tells me how important it is to grow beans. She emphasizes this when she says, with exasperation: "Beans, they are too expensive, R65 for 5 kgs!" She harvests seeds from most of her vegetables, such as beans, peas, spinach, pumpkins and beets. Faseka has a beautiful garden with many vegetables and an orchard of fruit trees. On a visit to her homestead, she takes me around her garden:

There are spinach, cabbage, tomatoes, peas, some older beetroots, sweet potatoes and a row of pawpaw trees. She dances in front of me as we walk around, clicking her fingers together and waving her hands in the air – "See my peach trees," she says, smiling, and I see that there are several with small peaches on them. I notice other fruit trees: mulberry, guava, bananas, lemons and naartjes (tangerines). There is also a greenhouse made (very fittingly) of green shade cloth and it is about 4 by 2 metres in size. Inside, there are areas that have seedlings of baby spinach, carrots, tomatoes, onions and cabbage growing. There are also gum tree seedlings, lucky bean trees, pepperdews (which she grows to sell to an outside market), avocados and some greens called pungempu for imifino. But all is not well in her garden! As I admire her garden, she reminds me that the rain has been intermittent and pests are hard to control without using chemicals. We look at a large plot of beans planted in rows – "These are healthier," she says, "but not really healthy." "Look my potatoes," she says, pointing to them, "they need rain." I ask about the mealies; they are planted together in groups of four or five and sort of in rows. "The reason I plant like this, if raining a lot, I cut here" – she points to just below the leaves – "and I will transplant here and it will grow again." She comments about the "takers" – cutworm, birds, etc. The sweet potatoes were planted a while ago and will be ready in January. They will take about four months to grow until harvest. Then she will plant again. The cabbages are already finished, but she has replanted. She points to her rows of mealies and says, "Look, my mealies are not alright; look, the colour, no rain!" I ask if we will plant more mealies today, as the holes are ready. She says, "If it rains, not, if it stops raining, yes." I ask about rain cycles, what is normal for the area at this time of the year (November). She tells me, "Small rain in August, September, upwards until now, should rain regularly – real rain, not this!" She holds out her palms and laughs, "This is not rain!" I ask her if it has a special name – she tells me it is "mkwitsho" (misty rain).

Faseka's garden is exceptional and not what most people's gardens look like. Her expertise has been developed over years of training and working. When I ask her how she knows so much about gardening, she tells me she had learned from her mother as a child, and then had studied at an agricultural programme as an adult. To supplement her income, she teaches mothers in the maternity and paediatrics wards at the hospital, about growing vegetables and how to make compost, in hopes of helping them to provide better nutrition for their children. She also supports women in the community in growing a garden to enhance their diet. Her task is not an easy one, as she says that many women would prefer to buy food from the store, especially the young ones, because they associate growing one's own food with poverty.

Imifino

Women gather wild leafy greens known as *imifino* to supplement the diet and to provide a healthy vegetable food at mealtimes, especially if they do not have a vegetable garden. Often considered to be common weeds by those who do not use them in their diets, *imifino* have healing properties similar to those in most dark leafy greens like spinach and kale. The collection and use of *imifino* is an indigenous practice that has been recorded as a supplementary food as far back as the late 17th century (Dold & Cocks, 2012). Generally, women gather the *imifino* and prepare it by removing the stalks and chopping it up, then boiling it for a short time in a pot and mixing it with fresh, coarsely ground mealie-meal. Many times when I was working in the preschool garden, women would stop and ask if they could come and pick the *imifino* that was growing: *utyuthu* (Cape pigweed), *umhlabangubo* (black jack) or *iguzu* (Cape gooseberry leaves), for their afternoon or evening meal. This was also the case with a colleague who would pick *imifino* from the preschool garden on a regular basis. New pumpkin leaf shoots (*ithanga*) are also popular as *imifino* and are slightly bitter in taste (Dold & Cocks, 2012).

Grinding stones are present in most homesteads for grinding maize and are used exclusively by women. To prepare the mealie-meal, women grind the maize kernels by kneeling on a special reed mat on the floor and crushing the maize kernels between a small stone and a large smooth grinding stone. The maize is then cooked in boiling water and stirred into a thick grainy “pap” (porridge). The *imifino* is then mixed into the pap, and together it is called *isigwamba* and eaten while it is still hot or warm (Kepe, 2001).

The reliance on *imifino* as a dietary food holds several values. Greater reliance on wild edible greens came about in rural areas, like the former Transkei, because as populations grew, less wild game was available as a food supply (Kepe, 2001). According to research on the nutritional properties of *imifino*, it has been found to contain high levels of protein, calcium, vitamin C and iron, and is part of the regular diet, often being consumed two to four times per week in the rural Eastern Cape (Kepe, 2002).

In the above sections, I have described several aspects regarding the ecology of a homestead. These descriptions were drawn from observations, field notes, and informal interactions and conversations with key informants in the village community. These descriptions highlight and begin to illuminate the complex social structures within a homestead.

The following section makes an analysis of the knowledge and skills needed to maintain a homestead, the social relations within the homestead, how the ecology of the homestead is related to well-being, and how Ubuntu manifests within social relations and the social structure of the community as a whole. This analysis will draw from my observations, informal and semi-formal interactions, and documentary texts.

Reproducing Knowledge and Skills

For most people, living in Mzingisi community requires knowing about and having the ability to execute the life skills necessary to maintain and sustain life in a homestead. Many of the skills are learnt at a young age, over time, while growing up or as an adult, collectively, in a “community of practice” (Lave, 1991), such as learning to collect and carry water, care for and slaughter of livestock, or tasks involved in building a hut. Here, knowledge is produced and reproduced through the social practices inherent in the lived-in world of the community (Lave, 1991: 67), and is developed through “peripheral participation” as an apprentice until mastery is gained over time. As such, the social structure is reproduced through the ongoing agency of the individual and the collective.

Maintaining Good Social Relations

Living on a homestead involves the ongoing maintenance of an array of social relations within the collective social structure of the household. These include social relations between various family members, their ancestors, livestock and the land, and can also include social relations with neighbours and friends.

Family Relations

Relationships between family members are based on gender and age hierarchies, with adherence to customary expectations and norms, both within the household and the macro community. This is particularly evident with regard to relationships between elders and their descendants and those between male and female family members. Customary practices require protocols between elders and younger descendants, with an emphasis on maintaining and practising respect toward elders. These protocols are also extended beyond only living members of the household, to deceased ancestors. This is particularly evident in the rituals that are performed to gain good relations and to maintain reciprocity between of the living and the deceased.

Relations with the Ancestors

Maintaining good relations with the ancestors is key to a good and fruitful life. The relationship is reciprocal and is “based on direct or indirect symbolic communication...by means of *ukuthetha* (to speak)” (Mndende, 2006: 5). Speaking to the ancestors requires specific ritual protocols (*isiko*) and is different from ordinary speech (Mndende, 2006). Honouring one’s ancestors is central in a homestead and plays a significant role in the prevention of possible misfortunes in the future. The roles that family members hold during rituals are highly gendered and based on age hierarchies, giving privilege to the elders. This is because elders are viewed as having personhood, meaning that they have developed themselves as human beings over their lifespan and therefore have the knowledge required to perform a ritual correctly, thus rendering the likelihood of one’s ancestors being happy and granting well-being to the homestead. The cycle of reciprocity between family members is an important and valuable one because if the ancestors are cared for and treated well, there is the knowledge that they will protect and care for their descendants.

Thus the well-being of the family is dependent on the quality of the relationship it has with the ancestors. This in turn extends out into the community because good relations between neighbours and friends support the living expression of Ubuntu, a key component in the development of personhood. With reference to Makgoro (1998), in order for one to have harmony between the spiritual and physical aspects of life, one has to have “close and sympathetic” relations within the social structure and be able to work through challenges presented from day to day (Makgoro, 1998: 2). This is explained by Ingold (2010), when he refers to Deleuze and Guattari ‘s (2004), contention that “the essential relation, in a world of life, is not between matter and form, or between substance and attributes, but between materials and forces” (Ingold, 2010: 2).

Gender and Power Structures within the Household

The social structure that underpins the maintaining and sustaining of a homestead is closely linked to gender-based roles. These roles are based on customary expectations and are integral to the smooth running of a homestead. Furthermore, each individual or collective role is linked to the sustainability and well-being of all present within a homestead.

Power relations in the homestead are generally hierarchical, with emphasis placed on patriarchies and age. The dynamics are complex. With regard to patriarchies, males generally have dominance in the home, with elders being given privilege and having the authority to make most of the important decisions. Women are generally required to adhere to their sometimes multiple gender roles as “wives”, grandmothers, mothers and daughters-in-law, which are also dictated by age hierarchies. In informal conversations with various women, I was told that married women are expected to obey their husbands’ demands, and that the women are generally powerless to do otherwise. This also means that women have little freedom to pursue work outside of the home, or have any control over money within the household, which causes tension, because most of the tasks required to maintain a homestead each day, are done by women. This is often difficult for women living only with their children, while their spouse is working as a migrant worker, only returning for short periods of time once or twice a year.

Oyewumi (2000) relates this to a generalized meaning derived from the African notion of “wife”, which differs from the “Western” concept. Across Africa, the role of wife is more prominent than the identity of wife, or the category of wife, which is subordinate, but not so much gender specific as symbolizing “relations of subordination between two people” (Oyewumi, 2000: 1096). This subordinating role can be contradictory because women may have a sense of freedom and power while their husbands are away, but when their husbands return, are then expected to do as their husbands say. This can often result in domestic violence, with women

being beaten if they are not willing to be submissive. Several doctors disclosed to me that they had treated many women who came in to the Outpatient Department at the hospital with injuries caused from domestic violence. Unfortunately, women in these circumstances have little power to change things, for fear of repercussions.

This state of affairs gives the impression that women are not valued or respected by men, even though on the surface, and as a collective value, married women are generally respected as mothers, child-bearers and nurturers of families. However, some unmarried women told me that they had no intention of getting married, even if they had children with their boyfriends, because they were able to have more individual freedom and power as a “mother” than as a “wife”.

In spite of gender inequalities and women seemingly getting the shorter end of the “domestic stick”, adherence to gender roles is embedded in the everyday flow of life. This is particularly visible in the ordering and layout of the homestead, where gendered roles and divisions of labour are symbolized in a number of ways. An example of this is the significance of the cattle kraal, which only men have access to. Considered to be a sacred space on the homestead, the kraal is viewed as symbolic of the lineage of male ascendants that dwelled there in the past, and is often memorialized by burying them in the kraal or performing ritual sacrifices in their name. This is perhaps reinforced with the task of raising cattle being allocated to male members of the family. In terms of gender-specific knowledge relating to women, there are the knowledge and skills used in the location and placement of the firewood pile (*igoqo*), which is symbolic of a hard-working woman who oversees the day-to-day running of the household. Perhaps of equal significance to the kraal, which is a symbol of male aspects and dominance over the homestead, is the custom of burying the placenta or a stillborn baby after childbirth beneath the woodpile, a symbol of female fertility and life-giving energy (Dold & Cocks, 2012). Then inside the hut, there is the gendering of space, with male and female areas allocated to specific sides of the room, which is perhaps not so much to “control” who goes where, as to provide order and meaning to seemingly mundane worlds. This is

perhaps what Giddens refers to as the rules that are attached to resources, where “transformative relations” are embedded in the “production and reproduction of social practices” (Giddens, 1984: 18).

The Relationship between Ubuntu and Well-being

Ubuntu is expressed between neighbours and relatives through actions of reciprocity and care. This is particularly evident in tasks having to do with maintaining the homestead, such as brick-making, harvesting crops, preparing fields for ploughing, fixing fences and rounding up wandering livestock, whereby neighbours provide help personally, or through able family members such as their children. This is often the case in households where women rely on the support of a male relative, because they are single or widowed, or their own spouse is away as a migrant worker. This practice of Ubuntu is known as *ilima*, because the help is given without any expectation of payment, but with an intrinsic knowledge that reciprocity will take place when their family is in need of support (Charnock, 2006).

Ubuntu also extends out to relationships with the land, because land use is collective, which is essential to the maintenance of a homestead. This involves sharing common land such as forests, springs, streams and rivers, rocks and stones, earth, wild-crafting of edible greens (*imifino*), and collection of grasses. Community members tend to gather what they can from the land and from the forests to help sustain their well-being. Having the knowledge and being consciously aware of the rhythms of the natural environment, and knowing how much one can feasibly take for personal use, is essential to ensure that there are still enough resources for others. It also requires knowing the collective “rules” present within the social structure of the community, as in Giddens’ “modes of social conduct” (Giddens, 1984: 18).

Some barriers to Ubuntu where people are unable to act with care and compassion are linked to issues concerning alcohol abuse and effects of poverty, which often

lead to theft, street violence and or domestic abuse. Robberies and violence typically occur at the weekends, on paydays, or during holiday periods such as Easter and Christmas when outsiders are visiting the community. Several incidents occurred while I was in the Mzingisi community, where doctors' homes were broken into and money and possessions were stolen. On one occasion at Christmas-time, the NGO volunteers' residence was broken into and volunteers were asked for cell-phones, laptops and money, while one of the robbers waved a knife around to make sure they knew he meant business. On another occasion when my car was being broken into, and the local pastor went out to see what was going on, the robbers fired gunshots at him. Luckily the pastor was not injured and the robbers ran away. All these incidents are signs of how people respond to the gross inequalities between groups of people in South Africa, which unfortunately results in people acting outside of Ubuntu

The Life-giving Land

The role of the land is perhaps the most significant aspect in the ecology of the homestead because most of the resources that contribute to livelihoods, such as food, firewood, water and earth, are sourced from the land, or are dependent on the land, such as livestock, agriculture and the creation of homesteads. Additionally, the knowledge needed to live on the land is produced and reproduced through the practices utilized on the land. Underpinning these practices is the collective cultural identity linked to the land and location of the community.

Food Security

Food is sourced from the land in the form of hunting, raising livestock, wild-crafting edible plants, or as a result of cultivating a garden. The knowledge and skills needed to accomplish tasks related to food security are mostly defined according to gender and age. While hunting and the raising of most livestock are done by men and young boys, the largest responsibility of providing food for the family is done by women,

by raising chickens and pigs, or by growing vegetables in a garden area on the homestead, or by gathering wild edible greens (*imifino*).

Sheep, goats and cattle are dependent on the land for grazing and play a significant role in providing the necessary food expected at religious and cultural rituals and ceremonies, and as sacrifices to the ancestors. Livestock is also raised for bride wealth, and so the land acts as a medium for providing food for the cattle, to ensure a healthy herd. While most people are dependent on and benefit from the land, it is the wealthier families that tend to benefit the most from communal grazing land because they have larger herds. They may also be able to access other resources by offering bribes to community officials such as sub-headmen (Kepe, 2002).

Shelter Security

Homes are constructed from the resources provided by the land in the form of trees, earth, stones, grasses and water. Reliance on these resources support shelter security for most families, as it is with these resources that homes are constructed and homesteads are developed. Many of the tasks related to the construction and maintenance of homesteads are gender specific or specialized. An example of this is the thatching of roofs, where women have the knowledge to gather the appropriate grasses, but men have the specialized knowledge to do the thatching; or when building, women make the bricks, but the men build the hut. Without access to these resources, most families would not have the means to construct their homes. Wealthier families may be able to afford to purchase the materials, but as construction may involve more modern technologies, they require the specialized knowledge of a skilled builder. This seemed to be the case for families that had members employed by a construction company responsible for building the new tarred road linking this community to other areas in the district. Other resources from the land, such as rock and stones, support construction of homesteads, as do the forests, which provide the poles for the main supporting structure and shaping the roof, and for construction of the kraals and fences.

The relationships people have with the land ensure that most households can cultivate basic livelihoods. However, the recent declaration in 2010, by the Constitutional Court, regarding the Communal Land Rights Act 11 of 2004 being unconstitutional, could change the dynamics for community members gaining access to land resources (Rautenbach, 2010). This could directly affect poorer communities such as Mzingisi. Land in the former Transkei has been loosely owned by the state, with most land being managed by local traditional authorities, enabling community members to apply to live on land from their local chief, who grants them “Permission To Occupy” (PTO) (Keke, 2001). In 1997, the Land Rights Bill was in the initial stages of being drafted by the Department of Land Affairs, with the intention of giving legal recognition to people living on communal lands, but was halted by a new Minister in 1999. When the new Communal Land Rights Bill came into being in 2001, land could be transferred into the hands of “traditional communities”. The new Bill, however, was criticized by many, as it could also allow for unelected traditional leaders to have control of the land, denying those who did not support their leadership the right to live on the land (Kepe, 2001: 32). According to two women I spoke with, married couples generally apply for land to build their own homestead, after they have lived with the husband’s family for a period of time after their marriage. Individuals or couples can also apply for a larger area of land for farming or other uses that could serve the community.

Joining Two Homesteads through Marriage

This section first describes the joining of two homesteads through marriage and follows with an analysis that shows how this practice is dependent upon and integral to the creation of individual and collective well-being. Descriptions are drawn from my observations, field notes, informal conversations and interactions, as well as semi-structured interviews with the bride and the bride’s mother.

Rituals and ceremonies are important events in the lives of most people living in the area and are fundamental to the well-being of individuals, families and the community. They are used to mark rites of passage, such as initiations, marriage, birth and death, and act as preventative and protective healing measures. For the purposes of this research, I have focused on the ritual of marriage to show how it is related to the well-being of the homesteads.

The Historical Context

Historically, marriage has been an institution to provide stability and build strong families and clans. Most marriages were arranged between the parents of the respective bride and groom, with negotiations usually being initiated by the groom's father. Sometimes, mothers or female elders could " earmark" the girl they were interested in (Mndende, 2006), but she had to be from a different clan, as marriage between two people of the same clan has always been strictly forbidden (Mndende, 2006). The clan would be informed about the intended marriage and elderly male "go-between" (*oonozakuzaku*) would act as negotiators for the groom's family. Their task was to build and ensure a good relationship between the two families (*ukwakha ubuhlobo*), and to be the main representatives on behalf of the groom's parents. This involved all the marriage negotiations and the payment of *lobola* (Mndende, 2006: 28).

The Importance of *Lobola*

The practice of *lobola* supports the development of a close relationship between the bride and groom's families, and is a contractual relationship between the two families (Mndende, 2006). *Lobola* is often interpreted as being a "bride price"; however, Mndende (2006) clarifies its meaning:

Lobola is not a uni-functional institution, but an institution with a large number of interrelated and integrated functions closely woven into the whole social structure and organization of the particular society and culture. Through *lobola*, then, a relationship between two families is built, and there is an exchange of responsibilities with an extension of new family ties. (Mndende, 2006: 32)

Moreover, White describes the role of “bride-wealth cattle” as “clear[ing] the path that joins two separate homes in a relationship of affinity” (White, 2001: 467).

For this research, I attended two stages of a marriage that were located in two different places. The first part of the marriage was for the preparation and cleansing of the bride, before being handed over to the groom’s family. The other part I attended was the final stages of the marriage, when the bridal party arrives with gifts for the groom’s family.

Preparing the Bride for Marriage

This cleansing ritual was performed to purify the bride before her marriage to ensure well-being for her and the groom’s family, and was mostly attended by female family members and women from neighbouring homesteads. According to my translator, it is called *Umngcamo Wentomnozana*, and is loosely translated as the “initiation of the womanhood”. When three teenage women came to my door a few minutes before I left for the ritual, I asked them if they knew what the ritual was, to which they replied that it was to prepare the woman for marriage. When I asked them if they would be going through it, they said that they would. The following describes my observations recorded in my field notes:

It was late afternoon when we walked towards the homestead. It was cold and the wind was blowing, and because it was later in the day, the sun would soon disappear. We entered through the back and walked down to where we could see a large group of women sitting on the ground wrapped in blankets. They were all ages, from young to elderly, each wearing a head-wrap and the traditional married women’s skirt and apron. A relative of the bride, who was sitting on a chair facing all the guests, got up and welcomed us. She invited us to sit by her and sent some children to fetch chairs for us. Next we were brought tea, which traditionally is made in the pot with the milk and sugar all mixed together. Its warmth was welcome against the cold. We were also given huge slices of traditionally baked “Xhosa bread”, which had a smoky taste from being baked on an open fire in a cast-iron pot. On the ground, next to one of the huts, were heaps of gifts. Many different sized baskets apparently filled with cloth and bread, buckets and basins of all colours and sizes, household tools such as brooms and brushes, blankets, and even a new double bed. We were also brought umqombothi to drink. It was passed around from woman to woman, each one kneeling in the

customary way before bringing the can up to her mouth to take a sip. Everyone sat around as we waited for the ritual to begin.

The bride came out of the hut wrapped in a blanket. She was bent forward so that you could not see her face. She headed to the kraal where the healer stood. She kneeled naked before him and he washed her with special herbs, pouring the mixture over her to cleanse and purify her. She was then wrapped up in a blanket before she sat down in the kraal. The healer was “praying” over her, saying things we could not hear. Another man was preparing the goat that had been previously slaughtered, which apparently the family would eat later. After eating the goat, the bride would be led to the groom’s home, where she would stay for two nights before returning again to the home of her birth for the culminating rituals. As it was beginning to get dark, we decided it was time to leave

In an interview a few weeks after the cleansing ritual, the bride explained to me that the ritual is known as *Umngcamo* and means to cleanse a person by slaughtering a goat. This cleansing ritual is conducted to make her strong and to prevent her and her new family from having bad luck during her married life. The purification ensures that she is free of poor health or bad luck that could bring problems into her future life as a married woman, such as not being able to bear children, or being disagreeable with the family. The bride said:

Kukususa amashwa.

It’s to remove bad luck.

Mhlawumbi xa ungade wende okanye mhlawumbi awuthandeki nasebantwini. Wenzelwa ukuba mawubenelakhi.

Maybe if you have passed the stage of marriagehood or if you are not appealing to people. The purpose [of it] is for you to have luck.

When I asked for an example, she emphasized:

Sesitshilo kaloku sathi iyeza lelokuba mawuthandwe zonke eza nto ukuba uzale.

We said that the purpose of the medicine is for you to be liked and to be fertile.

The bride’s mother talked about the necessity of adhering to the practice, which is believed to be essential for the bride’s well-being:

Ndadiyenza kodwa la nto umthetho wayo mhlawumbi iyenzeka xa umntu engazali malunga umntu unezinto zekhaya ezingenzekanga. Qha mna ndiye ndamenza ngelixa ndimsayo. Ndifuna angabi nangxaki.

It's [the traditional practice] done when someone is unable to have children or probably there are certain things that don't work well in his/her life. I did it for her when I was taking her [to the groom's homestead] because I don't want her to experience problems [when she gets there].

When I asked if all women are required to do this before they are married, she responded by saying:

Isenziwa gqithi ngoba ngumthetho. Ukuba awuyenzanga uzagula ngoba kaloku kudityaniswa abantu abadala ngapha nangapha. Njengokuba ndixhele le bhokhwe napha kuxhelwe ibhokhwe. Kudityaniswa izihlwele, abantu abangasekhoyo, abantu abadala basekhayapha. Kudibane abalapha nabasemzini. Kudityaniswa abantu abadala mabadibana kuba loo mntu angaguli.

Yes, because it's mandatory. If you don't do it you will fall sick because it involves the old people [the ancestors]. I have slaughtered a goat here and so have they there [at the groom's homestead]. This involves the community, the departed and the elders, so that this person [the girl] doesn't fall sick.

Because I had only witnessed some of the ceremony, I asked the bride to explain what happened after the cleansing. This is what she told me:

Ndazoyalwa, ndazotya la mbengo ndodwa ukugqiba kwam ndayisusa la ngubo ndanxityiswa. Njengokuba bendinxiba iinto zam, iilokhwe zam.

I was given advice; ate the roasted meat alone, and when I was done, I removed the blanket and put on my clothes.

The bride's mother explained further:

Uzakuphuma kaloku simbeke apha, ayalwe ngooyise. Athi akugqiba kuthethe mna, kuthethe nabanye oomama. Simfake imbhola ebusweni, atsho abhinqiswe ke ngoku anxityiswe imibhaco, aye emzini ke ngoku.

She will come out, will be seated over there, and will get advice from the elders. When they are done, the other women and I will give a talk. [After that] we will smear her with red ochre on her face and then she will be girded with something around the waist, dressed in traditional clothes and sent to the new home.

The mother continued:

Njengokuba kuxhelwe le bhokhwe, kulempahla kukho i-emela ezi ingathi ziinkcenkce, zinemiqheba. Ibhokhwe kufuneka ifakwe kula emela, ayithwale ngokwakhe entloko xa aphuma nayo endlwini. Uyakuthwaliswa ngomnye endleleni kodwa xa seyofika

Since the goat had been slaughtered, amongst those clothes there's a metal bucket, the one that has handles. The [slaughtered] goat should be put in that bucket and she must put it on her head when she goes to her [new] house. Another person on the way will [probably] help her to carry it, but when she has neared her destination, she must put it again on her head, because it's hers.

All the above descriptions show how the practices surrounding the cleansing ritual adhere to protocols and rules that are believed to be imperative for the bride to have a bright future. The success of the ceremony weighs heavily on all those participating, but particularly on the traditional healer, the bride and her family. The ancestors also ensure that the bride does not carry bad luck with her to the family she's marrying into. During the cleansing, the ancestors are informed that she is leaving the homestead of her birth and going to the homestead of her husband's family, where they will be able to find her in the future. The traditional healer is the family healer, who has the authority and knowledge to carry out the ritual and mediates the cleansing by preparing herbs and purifying her with his medicine and prayers. This is accompanied by the slaughtering of a goat, which according to the mother, aids in the purifying of the bride.

The Significance of a Sacrifice

The slaughtering of the goat as part of the cleansing ritual is also an important mediatory experience, serving both as an act of "cleansing" and as a means of securing a connection between the ancestors and the living family members. The goat is slaughtered inside the kraal, which is not only considered a sacred space, but also a place of power and a place where one can communicate with the ancestors. It is inside the kraal where the announcement to the ancestors is made, telling them that the bride is leaving the homestead of her parents and moving to the homestead of her in-laws. Mndende (2006) reminds us that whenever there is a ritual

slaughtering, there are also words spoken to the ancestors. This is to inform both the ancestors and the community why the ritual is being performed. Mndende (2006) speaks of *Umngcamo* historically being a sacrifice of a white goat, which is believed to bring blessings. Specific parts of the animal are offered to the bride, usually the right shoulder, after it has been roasted over a fire (Mndende, 2006:).

This bride was in her mid-thirties and already had two children with her husband. According to her mother, this meant that the bride's father did not need to be "asked" (get permission) by the groom for the marriage, nor the bride "abducted", as in the old days. The mother explained:

Yena kaloku akathelwanga. Uthe uyise akafuni makathwalwe ufuna ukumsa nale bhokhwe kula mzi ngoba akanakwazi ukuba makathwalwe kuba senabantwana. Ungumfazi kufanele ukuba makangathwalwi. Uthe akanamntwana unokuthwalwa ngoba senabantwana bakhe balamzi. Ke ngoku kufuneka asiwe ngobulotyolwe. Ke ngoku kufuneka amse ngale ndlela kufuneka amse ngayo. Akufunekanga athwalwe ngoba kaloku mdala.

She was not abducted [or married in a traditional form]. Her father didn't want her to be asked for marriage. He wanted to take her to her new family with the [slaughtered] goat, because she already has children. She's a [matured] woman so she cannot be abducted [or married in a traditional sense], because she already has kids in that family. So now she must be sent [to the new family], because she has already been paid for with the bride price. She must not be abducted, because she's old.

Despite this, the mother wanted to follow all the necessary procedures, and added the following:

Ugqibile ukutshata yena ngoku angayifaka imisesana kodwa ke ngokunokwam phaya ndimsile ngoba bendiyithatha inkomo ngesisiXhosa sam ndiqonda noba uyintoni ke ndisezophinde ndiyomtshatisa. Ikhona ke la nto kuthiwa kutyiswa amasi ndisezokuphinda ndiyomendisa ndithenge impahla kugcwale indlu. Ndiyomendisa ke. Ndithi kula mzi ndicela ukuba ndimtyise amasi ngoba ngoku yibhokhwe apha. Kukho igusha yona kuthiwa yeyamanzi elandela le bhokhwe. Igusha le yeyotyisa amanzi. Ukumsa kwam kuzakuxhelwa inkomo ngoba kuthiwa wenziwa ezinye izinto ezinkulu. Andizukuphinda ndenze le nto bendiyenzile. Ndimgqibile ngoku umntana ngoku.

She's done with the marriage ceremony and she can put on the ring, but when I took her to her husband's family I told myself that I will again give her in

marriage. There's this thing called "kutyiswa amasi";¹¹ I will still give her in marriage, buy clothes, and this house will be full of people. I'm going to give her in marriage. In that house [the husband's family] I will ask them to give me permission to feed her with "sour milk", which is a goat. There's a sheep (which is for the "feeding of the water"), which follows the goat. When I take her [to her husband's home], a cow will be slaughtered for other traditional practices. [After that] I've done now performing [my] child's [traditional practices].

Mndende (2006) confirms that a piece of roasted goat's meat is given to the bride before she drinks the *amasi* (sour milk), and this is a time when the couple is advised by the elders.

While "abduction" was not part of this bride's experience, it has been the experience of some of the older women in the community, and unfortunately has been used criminally as a means of kidnapping young girls and taking them to other communities to marry older men (Malan, 2011).

In an interview with Nomvula, a woman who is in her fifties and grew up in the community during the 1960s, she told me the following story about her experience of getting married:

Umtshto yayingowesiXhosa. Ndandisendiswa ngabantu besiXhosa ngela xesha ibingekabikho le nto yaloo mtshato wasecaweni yaye yayithanda ukwenziwa ngabantu abafundisiweyo. Ukwenda kwam mna, kusuka abantu kwakowabo benkwenkwe beze kowenu ebantwini abangootata kutata wakho. Kuthiwe kuzocelwa intombi: "apha siphandlwe sinesitya apha esisibonileyo esihle. Siphandliwe ke yintombi yadsemaThileni. Ngoku ke sizocela" Bathetha notata. Kuvunywe kutshajwe inkomo. "Inkomo zingaphi?" Kubethwe ke ezo nkomo mhlambi kuthiwe zine. Mhlambi kuthiwe zintlanu bathi, "Hayi! Akunolunga yongezani." Kongezwe ke kwezonkomo zibe lelonani bavumelene ngalo. Mna ndithunywe ke ngoku evenkileni mhlambi ndithunywe komnye umzi ngapha eskhaleni kuthi mandiyothatha into phaa. Sihambe mhlambi ndithunywa nabanye. Xa usendleleni uyodibana nabantu. Nizintombi zoobani? Hayi singabaka- Niyaphi? Siya eKuthini. Hayi ke ntombazana, njengokuba bekusithiwa bhaka ngapha eKuthini, ubuthunywa ngapha eSkhaleni, sihamba nawe ngoku sigoduka nawe, uyokwenda. Sikucelile kowenu. Uthathwe

¹¹ "Ukutyiswa amasi" literally means "to be fed with sour milk". It has to do with the welcoming of a new bride to her husband's home or clan. For this practice to be effective, a goat is slaughtered and sacrificed to introduce the new family member to the ancestral spirits. The practice can only be performed in the presence of women (Translator, 2012).

ukhal'unjalo. Uxakathekiswa kuhanjwe nawe. Uyokwenda ke ngoku emzini, ufike ubekwe phaa kondlalwe ikhuko kula ndawo. Uyayibona ikhethemiya, iqhiya. Kuthathwe la khethemiya ke. Unxityiswe yona. Ihle amasondo kwezi ndawo. Uhleli emva kwela cango, ulila akumnandanga. Uyalila. Intliziyo yakho ayibuhlungu. Kufike abantu bakowenu bazokulobolisa, bahaambe nezonkomo. Ushiywe kuloo mzi, bahambe bona bagoduke. Ulile ulile ude uhlale. Mhlambi uzimele, omnye azimele abaleke aye kude, abuye mhla kwazeka laa ndoda kubekhona ubuyayo. Omnye ade ende ke ahlale kuloo mzi, omnye abaleke mpela angade abuye. Kuze kengoku, kusukwe kowenu kuziswe impahla, kuthathwe inkomo kuziswe impahla, kuxhelwe ibhokhwe kowenu nalapha emzini kuxhelwe ibhokhwe, ungcanyiswa. Ngulaa mtshato wesiXhosa ke ngoku. Kuthiwe uyancanyiswa. Kuziwe pha kowenu kuxhelwe inyama kuze nonozakuzaku, abafana abazobababini befake iifaskoti beququzela. Kubekho iintombi eziyakutheza zineda loo makoti, nazo zizogungxa nalo makoti. Nazo zigungxile, zibhinqi'imibhaxo le yeyaXhosa njengokuba ubhinqile. Nazo zibhinqile, zixakathile, zigungxile nazo. Kuthiwa kukugunxa ukufaka iqhiya kanje. Kuthathwe into ifakwe apha. La qhiya ayiqhinwa, kufakwa intsimbi. Kuphekwe iinyama kutyiwe. Nonozakuzaku babebabini. Kukhona noomama nootata abakuzisileyo. Uziswa ngootata abadala. Uthathwe ke ngokwesiXhosa kuthiwe utshatile. Qha ke ubungenasatifiketi ke loo wethu umtshato. Qha ngumtshato wesiXhosa. Kuthiwa kukwendiswa.

It was a Xhosa traditional wedding. I was taken into marriage by Xhosa people before the existence of a Western or church marriage, which was prevalent among educated people. When I got married, there were messengers sent from the boy's home to my home to speak to my father. They were older men. They came to ask for the girl: "We have been temporarily blinded in this household. We have seen a beautiful dish. So we were blinded by this beautiful girl of this clan. Now we've come to ask for her hand in marriage." They spoke with my father. They reached an agreement and there was a charge of cows, "How many cows?" Then they would probably agree to pay four cows or there would be an objection, "No! Add more." Then they would probably add five or more. I would be sent to the shop, or probably sent to another house at Skhaleni, to go and fetch something. I would probably have been accompanied by others.

On our way we will meet people. "Whose girls are you?"

"We are so-and-so's children."

"Where are you going?"

"We are going to eKuthini."

"My child, they sent you at eKuthini, but you are going to Skhaleni. You are going with us. You are going to get married. We have asked for a hand in marriage at your home."

Then they will take you. When you arrive at their place, they will spread a rush mat on the floor and will put a doek [scarf] on your head. You are crying at

that moment. Your heart is sore. Your family arrives to hand you over for marriage and then leaves with the cows. You will cry until you stop. Your family members will bring you clothes. Then there will be a slaughtering of a goat at your home and here in your new home, and then they will perform a ritual of ukungcamisa [where you are made to eat a ritual animal to mark the initiation into the new stage of life.] Then they will come to your homestead and slaughter. There will also be negotiators, two young men who are wearing aprons and busy engaged in making preparations. Then there are young women who are going to fetch wood from the woods in order to help the bride. They are also covering their heads with doeks and wearing their traditional skirts. Like the bride, they are also wearing a blanket/shawl over their shoulders. Then meat will be cooked and people will eat. There are two negotiators, older women and older men. You are brought [to your home] by older men. Then you will have a traditional Xhosa wedding.

Nomvula's description of her marriage experience shows how important the negotiations between the messengers from the groom's family and her father were in mediating an agreement regarding her impending marriage and the terms of the *lobola*. It also appears that when she was handed over to the groom's family, she had no time to personally prepare for the event and was immediately taken to the groom's family shortly after the negotiations were completed. Soga (1931) explains that messengers, known as *abahloleli*, are sent from the prospective groom's family to inform the prospective bride's family to begin the marriage negotiations. At this time, a number of cattle are given to the bride's family as a security until the marriage takes place, at which time they become part of the *lobola*. The bride is then taken to the groom's family with a bridal party (*uduli*) that remains there with the bride until the *lobola* cattle arrive. Then the bride is initiated into the bridegroom's home by eating the meat of a goat, which has been slaughtered for her by the groom (Soga, 1931: 234).

Nowadays, when the new bride is handed over to the groom's family, she takes with her a number of gifts (*umombeso*) that are given to her mother-in-law – as we shall see shortly – to distribute amongst her female offspring and relatives. These gifts are not only given as goodwill from the bride's family, but can also support her in her integration with the women already established on the homestead. Gifts

comprise sedge-grass mats, woven baskets, and an assortment of brooms, buckets, storage containers and other essential household items. The broom is particularly significant because it symbolizes respect to the ancestral faith in the newly married couple's home, and is believed to protect the home from being struck by lightning (Dold & Cocks, 2012: 138). Mndende (2006) explains that elders, young girls and young men from the bride's family are selected to accompany the bride and officially hand her over to the groom and his family. This bridal party is known as *uduli*. A hut, called *indlu yoduli*, is given to the bridal party to occupy for the duration of the event. Usually an animal is slaughtered and shared with the bride's attending family members as an official welcome to the bride (Mndende: 2006).

Handing the Bride to the Groom's Family

Following is a description from my field-note observations of the stage of the wedding when the bride was being handed over to the groom's family. It was a warm and sunny day, and I went with my translator and four university students who were doing internships at the hospital for a few weeks. While walking to the wedding, we met a woman along the way who immediately knew where we were going. She smiled and told us gleefully that we were all going to the same wedding, and to follow her. A group of children accompanied us, running along beside us, chattering and laughing as they went.

When we arrived at the homestead (umzi), we were led to the bride's family who were inside a hut. We were welcomed by the elder women, and given a place to sit down on the floor in front of the many women already sitting on the floor. The hut (indlu yoduli) that we were taken to was specially designated for the bride and her male and female relatives. The men were on the left of the hut (the male side), and the women, who were mostly unmarried young women, sat on the right-hand side of the hut (the female side). They were sitting, leaning into one another sideways along the wall – with their heads facing the back of the person in front of them. When the male elders from the groom's family entered the hut to speak, the women all lowered their heads, then almost lying down sideways, turned their faces into the back of the women next to them, to show respect. After we sat down in front of the women, we were immediately given pieces of meat to eat. Shortly afterwards, a man came inside and delivered a crate of beer, a crate of soft drinks and a bottle of gin, for the people inside the hut to consume. We were given a large bottle of "lemon twist" to share, which was much appreciated, as it was so hot inside the hut, and it helped to wash down the rather

chewy meat. There were two men dressed in “women’s” aprons that signified that they were the designated helpers for the event.

After listening to several speeches being given by male elders, we were taken outside to join the women who were sitting outside, grouped according to their families and the areas they came from. Each group had a pail of traditional beer (umqombothi), soft drinks and a bottle of liquor. We were welcomed and given a place to sit next to a group of women. The men were all sitting around the outside of the kraal and were also drinking and enjoying the celebration. From here we watched the women from inside the hut (indlu yoduli) come outside and line up, according to their ages, from oldest to youngest, to form a procession to meet more of the bride’s relatives who were coming down the hillside carrying gifts of baskets, basins, buckets, a double bed, cooking pots and food. These gifts were to share amongst the groom’s female relatives.

Before they descended into the homestead, elder women started waving flags above their heads and ululating and yelling that the gifts had arrived. Several men and women began dancing rhythmically, the men stabbing their sticks into the air in time with the beating of the drums. Then the arriving bridal-party procession continued, with each person or pair depositing the gifts next to the kraal. Then women danced in groups of three or four, while others stood around clapping loudly, setting the rhythm, their hands lifted into the air or in front of their chests. Several dances were danced at different tempos, with feet moving quickly in step with the clapping.

The above descriptions present a colourful picture of this stage of the marriage and the emphasis that is placed on protocols. This was particularly evident regarding the procedures that took place inside the bridal hut (*indlu yoduli*), and with the formalities of the speeches and welcoming the bridal party as it arrived down the hillside. According to my interpreter, the words delivered by male elders who represented the bride’s family inside the hut, were to acknowledge that the marriage negotiations were complete and were confirmed by the response, “*enkosi*”, that was said repeatedly after an elder spoke. Soga (1931) explains that the main addresses given to the bride and groom are first given at the homes of their respective parents. Then after the marriage ceremony, elders address both parties. First, to the bride, who is told that she is no longer a child, and is warned that she must work hard and conduct herself in an appropriate manner, and that she must not bring shame to her family. Then the groom is told to be a good husband to his wife and to treat her well, and is told to remember the proverb, “*induka ayina mzi*” – “a stick destroys home life” (Soga, 1931: 235). The following section analyzes some

of the above descriptions and the relation between gender roles, knowledge reproduction and the patriarchal system.

Gender, Knowledge and Maintaining the Patriarchal

The descriptions above indicate that family systems in the community are patriarchal and give privilege to males, particularly elders. Marriage is negotiated through the fathers or elder males of the families involved, and they are the ones who finalize the negotiations at a wedding. It is also expected that the new bride (*umakoti*) leaves her family's homestead and moves to her husband's family's homestead, where she is under the command and tutelage of her mother-in-law, serving as her "daughter-in-law" for at least one year. This requires doing many of the household chores, including cooking for the family. Mndende (2006) explains that the past custom of arranged marriages helped ensure that a hard-working and responsible daughter was chosen for their son. "It was rare that a daughter from a lazy family would be considered a diligent future wife" (Mndende, 2006: 27). Women are required to adhere to the privileging and dominance of men, and generally behave according to the expectations and norms that custom demands. Married women, although often revered as stabilizers in the family, the bearers of children and the source of sustaining the homestead, hold little individual power in the patriarchal hierarchy. This means that women usually do not have a say in family matters and have to be submissive to their husbands, who make most of the decisions. Unfortunately, the abuse of married women by their husbands is common, and *lobola* is no longer the strongly valued artefact it once was in preventing abuse from occurring. *Lobola* has multiple functions woven into the social structure of a culture and community, and through *lobola*, a reciprocal relationship is built between two families, which carries with it an exchange of responsibilities (Mndende, 2006: 32). Historically, *lobola* served as a preventative tool against the abuse of a married woman, and was a guarantee that she would be treated well by her husband (Soga 1931). Soga emphasizes this in the following:

In no country civilized or uncivilized is there any custom so powerful, I believe, to secure the status of the married woman, and to protect her from physical abuse. It may seem to some that this is an unwarranted assertion to make, but I make it without hesitation. (Soga, 1931: 263)

Married women are also expected to follow strict codes regarding clothing and are required to wear the traditional *umakoti* skirt and apron, and a *doek* or hat to cover the head, which, according to a colleague, must always be worn in public. This constitutes a structure of signification (Giddens, 1984), indicating to the community that one is married. Male privileging is also dominant when considering the ritual cleansing of the bride, because it is only the woman who must be cleansed before the wedding, so that she is not a harbinger of bad luck and “evil forces” that could potentially cause harm to the family she is joining.

At the marriage ceremony, where the bride was being handed over to the groom’s family, the specific customs and rules that had to be followed by the women who were in the bridal hut also made this male privileging visible. All the young women from the bridal party were sitting on the “female” side of the hut, which is the right-hand side, but they also sat in a particular way – with their eyes cast downward, or hidden in the back of the woman sitting next to them, and close to the floor. This practice signified respect towards the elder males, especially when a male elder entered the room. Further indication of honouring the patriarchal was the bridal party’s practice of delivering gifts to the groom’s family, and presenting them next to the kraal. It was also the groom’s mother who distributed the gifts amongst her female family members, although according to the bride, some of the gifts would be given to her, at her mother-in-law’s discretion. This was also an indication of Ubuntu in practice, where the collective was honoured on behalf of the individual.

Although men were privileged, they were not excused from following certain protocols during the marriage ceremony. They too sat on a specific side of the hut – the left, which is the male side – and spent their time outside sitting around the

exterior of the kraal, which is a designated area for men to congregate. The male elders representing the groom's family were required to speak to the bride's male family members, one by one, their words holding specific significance and purpose for the completion of the wedding negotiations. Here, the power dynamics were clearly dominated by the male elders, who were continually shown respect and who had made the most important decisions. This not only reaffirmed that protocols had been followed, as was expected, but also provided a framework of knowledge for future marriages within the family and community.

Gendered Knowledge Reproduction

The knowledge that was embedded within the cleansing ritual influenced the family members' roles and tasks, which included gender and age hierarchies. During the ritual cleansing, the women elders shared their knowledge and wisdom as they advised the bride of the responsibilities of marriage and her duties as a new wife (*umakoti*) and daughter-in-law. Younger women, on the other hand, who were not yet privy to this knowledge, had age-appropriate roles and performed menial tasks, such as preparing tea for guests and helping to get the homestead ready for the ceremony, collecting water and firewood. Because custom requires that men always do the slaughtering of animals, designated males had the duty of slaughtering the goat, preparing the fire and roasting the meat for the bride to eat.

The traditional healer, according to the bride's mother, was a clan member and the family's traditional healer, and was integral to the health and well-being of the family. By providing the traditional medicine needed for the bride's cleansing, and performing the purification ritual in the correct way, there is sanctioning from the ancestors and the bride is protected. Due to the significance of the purification ceremony, the cleansing of the bride took place inside the kraal, normally men's domain; but in such circumstances, an unmarried woman may enter the kraal. The bride's mother explains:

“She's the daughter of this home. People are not allowed to enter the kraal even with us; we only enter the kraal when we need to wash with medicine.”

Flexibility and Change

While there are seemingly strict rules in place for married women, these codes are more relaxed and flexible if the women are educated or practising Christians. Within the “*longue durée*” of community life, this discursive reflexivity (Giddens, 1984) is perhaps due to the understanding that the more restrictive expectations are linked to traditional spiritual beliefs and practices. Therefore, allowances are made, knowing that there have been influences from other sources and experiences. This seemed to be the case in the experience of a friend, who told me what her father-in-law had told her to do in the case of an emergency situation, when no men are around: if the sheep are out of the kraal or need tending to, she must enter the kraal and save the sheep, but she must also adhere to the expectation requiring that she wear the appropriate attire of a married woman, which includes tying a woollen scarf around her hips and across her bottom, in the traditional way.

While unmarried women apparently have the freedom to wear whatever they want, even within this flexibility, there are tensions that stem from embedded beliefs, such as invoking the wrath of the ancestors, which is seen as a punishment for deviating from expected codes of behaviour or ways of being. This was the case when some women in the village were struck by lightning, and the cause was linked to them wearing trousers.

Conclusion

This chapter has described how well-being is cultivated within the ecology of the homestead, and how marriage contributes to this well-being by joining two homesteads together. Through these descriptions, I have argued that the knowledge integral to well-being is produced and reproduced through the carrying out of the everyday practices conducive to maintaining and sustaining a homestead, and that the knowledge and skills are developed through participating in situated communities of practice. I also argued that Ubuntu is embedded in everyday

practices, especially with regard to land and resource use and in the practice of marriage. Descriptions were drawn from my observations, field notes, informal conversations and semi-structured interviews.

CHAPTER FIVE HEALTH PRACTICES

Introduction

It was stated in Chapter One that the primary focus in this research is the exploration of indigenous knowledge practices that are related to women's spiritual and physical well-being, and the kinds of choices that women make towards cultivating and sustaining their well-being. In Chapter Four, I gave a detailed description of village life through the lens of the ecology of the homestead, which provides a backdrop for how and why women make the choices they do around health care practices.

This chapter begins with a detailed description of the health practices women utilize for their individual health and well-being, and how those practices relate to the well-being of the community. First, focus will be placed on traditional healing practices, and then on "Western" biomedical practices. Descriptions will be drawn from my fieldwork observations, field notes, informal conversations and interactions, semi-structured interviews and documentary texts. An in-depth analysis of some of these practices will follow in Chapter Seven.

Health practices in the Mzingisi community are varied, and people living in the village and outlying areas choose different methods of healing to support their health and well-being. At the centre of the community is a government-funded hospital that is run by the Eastern Cape Department of Health, which provides non-specialized biomedical care to approximately 130,000 patients living within a 1,000 km² radius of the hospital (Gaunt, 2010). People who live within close proximity of the hospital usually visit the Outpatient Department (OPD) if they are sick or injured and need to see a doctor, and many women go to the hospital to deliver their babies. There are health clinics scattered throughout the region that provide basic health care, antenatal services and HIV/AIDS treatment (ARV distribution) during the

daytime; however, they are rarely staffed by doctors. There are also traditional healers or diviners (*amagqirha*) living throughout the area, who treat people for many illnesses, especially those that are viewed as being untreatable with “Western” or biomedical methods. In the following section, I will describe some of the traditional healing practices shared with me while conducting this research, and will use both terms, “traditional healer” and “diviner”, interchangeably.

Traditional Health Practices

Traditional healing is provided by a traditional healer (*igqirha*), and is considered to be a gift from the ancestors (Mndende, 2006). The word *isangoma* is a Zulu term that was often used in the Mzingisi community and is also understood to mean diviner. The term “traditional healer” has been argued to be inappropriate because it suggests that the healing practices are derived from stagnant and unchanging beliefs and practices (Thornton, 2009). With respect to this research, it is my intention to recognize that “traditional healing” is practised within a dynamic and changing culture and therefore has developed and continues to evolve over time and space.

Many people visit traditional healers to have physical, psychological and spiritual issues and illnesses treated, and to receive protection from evil spirits and bad luck. A traditional healer’s first priority though is the health and well-being of his/her own immediate family. The isiXhosa word *impilo* is all-encompassing regarding health and well-being, and although there is no direct translation into English, it broadly means “fullness of life” and to be “in harmony with the cosmic vital force”. Thus *impilo* not only includes the well-being of a person’s body, but also that of the whole family and homestead (Jansen, 1973: 38). The isiXhosa term *ndiphilile* (I am in good health) stems from the verb *phila*, which means to be in good health (Dold & Cocks, 2012: 37).

In Xhosa cosmology, one's level of health and well-being is related to the state of one's relationship with the ancestors. To have good health and blessings in life, one's family must be in good standing with their ancestors. Misfortune, bad luck and illness are a sign that the balance between family members and their ancestors needs to be restored (Jansen, 1973). People who seek help from a traditional healer may also believe that illness can be caused socially or culturally. Social illnesses are said to be caused by ancestor spirits or witchcraft, and can be prevented through carrying out the necessary ceremonies or by wearing a charm containing medicinal properties (Chavunduka, 1994: 69). Culturally related illness is known as *ukufa kwamaXhosa*, meaning that Xhosa illness is treated through traditional healing (Dold & Cocks, 2012: 22). Misfortune, believed to be caused supernaturally, can also be cured with Xhosa medicine (Dold & Cocks, 2012).

Most people in the Mzingisi community seek help to cure their personal ailments and illnesses, or those of their children, and are willing to pay the healers a considerable amount of money for their services. The traditional healers I interviewed told me that payments varied and were necessary for the healing to be successful. Dold and Cocks (2013) claim that many healers have other employment to supplement their work as *amagqirha*, as the amount they earn for healing services is usually not enough to live on.

***Igqirha* (The Diviner/Traditional Healer)**

The healing practices of a diviner or traditional healer are holistic and embrace the "biological, physical, spiritual and social aspects" of a patient (Mndende, 2006: 49). Traditional healers gain knowledge about their patient through divination and consultation with their ancestors, and aim to help people from various backgrounds regain balance in their lives by prescribing appropriate medicinal remedies or performing special rituals.

Traditional healers can usually be identified by the special attire and adornments they are wearing. They were often observed in the village wearing special clothing and/or necklaces, bracelets and anklets made of mostly white beads, with a row of coloured beads inlaid. During my fieldwork, I noticed several traditional healers in the village community, most of whom were women. Occasionally, I would see a group of healers walking through the village together all dressed in white, carrying small bags of healing tools and their sacred reed mats. I also observed a herbalist (*ixhwele*) from time to time walking through the village or waiting at the taxi rank. He was wearing a symbolic red and white robe wrapped around him and red and white beads around his head. He also carried a special carved wooden stick.

While conducting this research, I visited two traditional healers, both of whom I interviewed, and one who did a divination session for me. One of the healers lived in the immediate community just below the hospital, and the other lived approximately 1.5 km further down the road. My first encounter with one of the traditional healers, Nolizwe, was while on a village tour, accompanied by a friend and my translator, who had arranged for us to visit her. The following excerpt from my field notes describes the visit:

As we approached the homestead, I realized that this was the home of a woman I had been greeting each day on my runs, and who I chatted with about building houses. So I wasn't so surprised to be meeting this powerful woman. She is a diviner (igqirha) and holds an important position in the Zionist church as a priest. She was happy to see us and gave us a very warm welcome, with cheers and big smile. She also recognized me from our previous encounters on the road early in the mornings. She was home with some young men and women who seemed to be her sons and their wives, and two other women who I think were her daughters. All of the women were wearing yellow headscarves signifying that it was Sunday and that they were Zionists. The hut was spotless and tidy, and had a dung floor and painted walls. On the left side of the room was a double bed and on the other side was a three-quarter bed. At the far end of the hut opposite the door, stood a long cabinet with shelves stacked high with pots, buckets, plastic containers and food. The healer's yellow cloak and other sacred clothing were hanging on the wall in the corner. To the side of her bed beneath the Zionist garments were her healing tools. A special stone for grinding herbs (lokukanda), a beaded stick with a cow tail on the end of it (itshoba), a bottle of clear liquor, and other sacred objects. She took down a suitcase and began taking out her special garments, holding each piece up to show us. There were several sets of beads, which she laid on the bed. Then she did what seemed unbelievable to me: she started to

dress my colleague in them! A headdress of white beads, a bib and apron made of blue and white beads, with a row of red and yellow beads inlaid, and a white woven cotton skirt with black stripes sewn around the bottom edge. When I asked her about someone other than herself wearing her sacred garments, she said it was fine and “nothing would happen”. Then the whole family wanted a picture taken of them with us.

As noted earlier, healers can be identified by the attire they are wearing and by some of the specialized objects used to mediate their practice of healing, and although their clothing is considered “sacred” and is usually kept in a special place, it seemed that it was not taboo for someone else to put them on. But although my friend was allowed to wear the beaded headdress and apron, she was not given the opportunity to wear the special beads worn all the time by the healer, or the cloak that was hanging on the wall. This might indicate that these particular items are sanctified and hold special meaning and purpose that cannot be transferred to another person.

Ukuthwasa: To Train as a Healer

Traditional healers (*amagqirha*) are always called to their work by their ancestors (*izinyanya*), who are related to them by clan (*isiduko*) and are usually revealed to them in dreams, sometimes appearing in animal forms such as lions or leopards (Jansen, 1973). Traditional healers complete a period of extensive training known as *ukuthwasa* and have to pass through several stages before graduating as *amagqirha*. The length of training varies and depends on the type of specialization and the time frame that is set by his/her ancestors. Mndende (2006) tells us that *amagqirha* can specialize in one of four areas, namely, the river, (*umzi omkhulu*), the forest (*engetheni*), caves (*emiqolombeni*) or the sea (*elwagcwebeni*). Herbalists (*amaxwele*) are not chosen by their ancestors, and usually train while working as apprentices to other herbalists (Dold & Cocks, 2012).

Intwaso: The Call to Healing

The first traditional healer I visited (Nolizwe) told me that she came from a line of healers and had been called to healing since she was a child. As with many traditional healers, she did not heed the call as a child and consequently became sick.¹² It was only in 2001, as an adult, that she began her training, which she completed in 2008. She explains:

Ndikhule ndigula ndigulela ubugqirha kodwa ndizokuncedakala ngoku ndisemdala ngose ndiyiboniswe ukuba kufuneka ndiyenze njani.

I grew up as a sick child becoming sick for traditional healing but I received [therapeutic] help when I was old, through dreams.

Kaloku ukuqala kwam ukunxiba intsimbi bekungo-2001.

When I started to wear my beaded necklace, it was in 2001.

The second traditional healer (Nosipho) I visited and interviewed also experienced illness before she decided to go through *ukuthwasa*. She describes her symptoms:

Mna ndagula ndaphathwa ngamazinyo, ndaphathwa yintloko.

I fell sick and had dental problems and a headache.

Ndingeva ngeendlebe.

I became deaf.

Ndaba ngathi ndizohlanya.

And it appeared as if I was going to lose my mind.

Mndende explains that would-be initiates often receive guidance from elders who recognize that the symptoms they are experiencing, such as sickness in some form or another, are linked to the call to becoming a healer (Mndende, 2006).

¹² Becoming sick manifests itself in different ways: fear, anxiety, delusion, hallucination and so on (Translator, 2012).

Furthermore, it is often when accepting the call to be a healer is delayed that sickness occurs (Mndende, 2001: 51).

Nosipho's training period to become a healer lasted for six months and entailed receiving training and guidance from a knowledgeable "master" healer who helped her develop her psychic abilities, which are needed to determine the severity of the patient's ailments and to find the right cure. Her first experience was dreaming about her trainer, as she explains below:

Ndaphupha ndilele. Ndaphupha umntu oseMzimkhulu oyena uzondithwasisa.

I dreamed while I was sleeping. I dreamed about someone from Mzimkhulu, the one who's going to be my trainer.

Nosipho went on to tell me how she was trained:

Uyafihlelwa into nokuba yintoni. Mhlawumbi masithi yena njeng'ba engumntu ofundayo, ndizakufihla iball pen yakhe. Kufuneka uyazi ukuba isendaweni ethile. Azithathele yena.

They conceal everything from you. Maybe, let's say since she [Yolisa] is an educated person, I will hide her pen. [As a diviner] you must know that it [the pen] is at a certain place. He/she must go and fetch it him/herself.

Masithi sichathe ezintonga, sizakuqala la, xa sibaqhatha. Ndizakuzithatha ndizifihle. Kufuneka nitsho ukuthi zindaweni ithile. Noba ngubani ndithi makahambe ayozithatha.

Let's say we touched these wooden rods; we will start here when we deceive them. I will take them and hide them. You must be able to tell where they are.

Xa ufunda ubugqirha, awufundi ncwadi, uyaphupha ngoba ulele. Uyaboniswa izinto ekufanele uzenze. Mhlawumbi uboniswe ukuba hambokha umthi othile, ingcambu elithile, uzoboniswa igqabi lokuba ngowomthi othile. Wenze uthi.

Traditional healing does not involve books. You just dream because you are asleep. You are shown things that you need to do. Sometimes they [the ancestors] reveal [through dreams] a plant or root you need to get. They will also show you the flower of this tree and give you instructions on what to do.

It was also through a dream that Nosipho discovered that she had gained enough knowledge and skills to be a diviner. She explains:

Ubakhona umntu oya kuye onazo zonke izinto ozothi ngemini ogqibile uyabona, laa nto kuthiwa nina niyothwala isidanga uyabona, agoduke nawe uzobona inkomo umbala ophatha ngalo ishoba. Uyabona elashoba limhlophe? Uzofika uti uboniswe inkomo enje nanjena. Uba isemzini uti isendaweni, ube uxelela yena. Yena ahambe akuse kulendawo inalenkomo. Ufike uchaze ububone kanje nanje nanje. Mna ke inkomo ndayibona emzini, ekhaya. Yakuthathwa ke ekhaya ndagoduswa. Unomntu ongudirector wakho, ongutisha.

There is a person who tells you at the end of the day that you are able to divine. It's similar to obtaining a degree. She or he (senior diviner) leaves with you so that you could reveal to them the type and colour of the cow you are seeing and the way in which you hold the tail. Do you see that white tail? When you arrive you will say you saw a cow of this type and you will also tell where it's located. Then she or he (senior diviner) will take you to the exact location and you will disclose your visions. I saw my cow at home. It was fetched and then I was sent home. The person is more like your director or your teacher.

Divination

The ancestors play a significant role in traditional healing and are accessed for their knowledge about a patient's ailment and where to find and prepare the appropriate cure. While divination is a diagnostic process, emphasis is often placed on determining the cause of the problem rather than the problem itself (Jansen, 1973). The traditional healers I visited both implied that they were "employed" by their ancestors, but Nosipho emphasized that her knowledge also came from God. In the following excerpt, she describes how she gets support from her ancestors:

Masithi ke umntu uyagula nhe. Mhlawumbi ugula yimilenze, mhlawumbi ugula yinto esesiswini. Mina ngizofika ngishaye ngikhulume nabantu abadala bengishela ukuthi ugula yinto ethile yenziwe ngokuthi be sengisazi ukuthi ngizohlenganisa.

Let's say someone is sick with sore legs or has a tummy-ache. When I arrive, I will talk with the ancestors and ask them to reveal to me what's troubling the person. When I know, I will do a concoction (a mixture of herbs).

Nosipho gives another example of how she uses the knowledge of the ancestors to help her diagnose how a baby is positioned in utero:

Isisu masihlele kabi mina ngizokubuza ezintweni zam kwenzakalani, mhlambi ngimphathe ifike ihlale phaya. Besengiyakutshela ingane ihleli kanjani esiswini, ngiyibone mhlawumbi ihleli kakubi. Besengimenzele isiwasho ngifike ekuseni ngimjonge ukuthi ihleli kanjani.

If the baby is not in the right position I will ask my ancestors to explain to me, or maybe I will massage the mother gently and tell her that her child is not in the right way. After that I will prepare her a traditional medicine for cleansing.

I was interested in observing and experiencing a divination, so I asked Nosipho if she would divine for me. I arranged for my translator to meet me at my house so that we could walk together to Nosipho's homestead later in the afternoon. I did not record the session, out of respect for her work. The following is a description of the divination, written later in my field-notes journal:

As soon as I arrived, the healer welcomed me inside and told me to sit down on the chair. She was sitting up on her bed wrapped in a blanket. There were several baby chickens pecking around on the floor at pieces of maize and maize crumbs. A fat chicken sat snoozing on a piece of cloth/clothes in the corner of her hut, seemingly oblivious to all the people and goings-on in the room. She got up and prepared the area, sweeping some of the maize bits out of the way. She unrolled a sea grass mat and put it down on the floor, and then picked up several strands of beads that were draped over the back of a chair. One set was made up of three strands of blue and white beads, which she placed over her head and right shoulder and another set was placed over her head and left shoulder, forming an overlapping X in the centre of her chest. She then took down her leopard-skin design cloak that was hanging on the wall and put it on – there was a big white cross stitched in the centre of the back of the cloak. She took out a cloth, which was also leopard-skin design and tossed her beaded cow's tail (tshoba) and wooden assegai (axe) onto the mat. She asked the interpreter to close the door. She unwrapped her headscarf and pulled down her hair, which was in long braids, and then told me to remove my shoes and put my feet on the ground where I was sitting. She began to pray, opening up the divination with prayers to the ancestors. After her prayers, she sat on the mat and closed her eyes so that she could "see" things about me. She began to tell me some interesting things, many of which seemed justifiable. She knew things about me that were true and could not necessarily have known about me unless I had told her. She also told me things like the "creatures" such as lizards in my house were protecting me and had been sent from the forest, and that I should not kill them. Periodically, she would ask if I agreed with what she had said. When she was finished, she asked if I had any questions.

After the divination, I arranged to return and interview her on another day, because I was particularly interested in the kinds of problems women sought treatment for.

Finding a Cure

Finding a cure involves knowledge from the ancestors, who are crucial in the healing process and act as intermediaries between the healer, patient and the Supreme Being. The prayers, or words spoken to the ancestors and the information that the healer receives from them provide the necessary means with which to treat a patient. Once a diagnosis is made, the diviner usually prescribes some form of Xhosa medicine (*amayeza esiXhosa*) made from herbs and plants and/or some animal derivatives (Dold & Cocks, 2012).

The notion of *amayeza esiXhosa*, according to Dold and Cocks (2012), was recorded in Rev. Albert Kropf's isiXhosa Dictionary, in 1915, as "*iyeza*", meaning, "medicine in the widest sense of the term, including not only curative and preventative but also those concoctions which are used as charms in witchcraft" (Dold & Cocks, 2012: 21). The notion of *amayeza esiXhosa* is also said to stem from two "root concepts": *ukuya*, which means "to go", and *ukuza*, which means "to come", suggesting that *amayeza esiXhosa* invites strength to come to the patient and for the disease to leave (Dold & Cocks, 2012: 21). In many cases, much like the two healers I interviewed, the ancestors guide the healer to the right cure via dreams, or during divination.

Herbal Medicines and Charms

The ingredients needed to cure the patient are gathered and collected in the form of plants, roots or tree bark, from places in the natural environment such as along the banks of a river or stream, or from within the forest. A diviner grinds the herbs with special stones called *ityje lokukanda*, before cooking or brewing them into the concoction (Mndende, 2006). Uncooked herbal mixtures are usually used for cleansing purposes, and the healer may also make a charm for a patient to wear (Nosipho, 2012). This is usually placed in a small purse that can be worn around the neck or waist, and is generally worn to protect the patient from being attacked by evil spirits. Sometimes special rituals can be held in the forest, near streams or

rivers, near the ocean, or in caves, depending on the specialization of the healer (Mndende, 2006).

Seeking Treatment

Both the traditional healers I interviewed stated that they treated equal numbers of men, women and children. But for the purpose of this research, my focus will be on some of the healing methods used in the treatment of women and children.

Treating and Healing Women

Women visit traditional healers for a myriad of ailments and may be given herbal concoctions, charms to wear, or herbs to cleanse with. The traditional healers I interviewed told me they treated women for many issues such as those during pregnancy or post-partum, or for conditions like infertility. Women also consulted them if they suffered from headaches or shingles.¹³ Some women sought treatment to help them find a lover, or to prevent a lover or spouse from being jealous, or from cheating. Nolizwe explains:

(Giggles) Kaloku kuyanyanzeleka umntu ndimlungiselele xa esizangoba nalapha ekuhlambeni kukhona uhlambele indoda yakho ikuthi ikuthande nomnye. Mh. Likhona elokuthi ubengumntu oright omhle. Akhona awokuthi ukhuph' ibhadi. Ngelixesha uhlamba ngeli yeza lokukhupha ibhadi, wenza ukuba ubenelakhi.

(Giggles) It's important for me to help that person because sometimes you cleanse yourself to be loved by your man. There's another one for beauty. Others are for getting rid of bad luck to be lucky.

Dold and Cocks (2012) explain that charms can be worn as amulets to bring luck, or repel misfortune and protect from danger. These charms may be created from a variety of special plants and trees and put inside a small container, and decorated with beads. Other charms may be prepared from plants and mixed with water for a person to wash with. A case concerning the use of charms seemed to be underway when we arrived to interview Nosipho. On arrival at her hut, I observed two women

¹³ Shingles is a painful rash caused by the varicella-zoster virus, which also causes chickenpox (www.mayoclinic.org).

sitting in the room, who looked like they were getting some kind of formula or charm to put in the cell phone – the healer gave one of the women what looked like a piece of folded up paper and put it in the cell phone under the battery, where it would do its work.

According to this healer, women may also seek treatment for health concerns during pregnancy or post-partum. For example, women who are having difficulty with breastfeeding may visit her for treatment to help the milk flow better. Nosipho explains this to me:

Izolo ebefikile. Yebo mhlawumbi masithi ingane iyalila, akulalwa. Ngizoqale ngijonge ukuthi yini. Bese ngiyamtshela kukhona umoya omdaka kumntwana, mhlawumbi yena uyancancwa yinto ethile, umoya omdaka. Ngimenzele iyeza ukuthi ingane ingakhali.

Someone came yesterday. Yes, maybe the child is crying and is unable to sleep. I will first check what the problem is and then I will tell the mother that the child has a bad spirit, or maybe the mother's breasts are being sucked by bad spirits.¹⁴ After that I will prepare a concoction which will stop the child from crying.

Ngizomnika into yokugeza amabele ukuthi ubisi luphume.

I will give her something to cleanse the breasts so that the milk can come out.

If a woman is pregnant, she might seek treatment from the healer to ensure a healthy pregnancy, or to ensure that the baby is in the right position before birth. As explained earlier, she could massage a mother's belly and check if the baby was in the right position, and if it wasn't she would consult with her ancestors and perhaps prepare a herbal concoction for the mother to wash and cleanse with. This and other practices concerning pregnancy and childbirth were spoken about in a Focus Group session with six Mentor Mothers outreach workers. One outreach worker emphasized that some women go to see traditional healers so that they can deliver their baby if they have exceeded the nine months of their pregnancy. She explains:

¹⁴ *Ichanti* is a multi-coloured snake that dwells in rivers and is believed to poison a mother's breasts by sucking them (*Uhlanzelwa lichanti*) (Jansen, 1973: 45).

Okanye kaloku ndidiniwe kukukhulelwa ngoku ngoba eziyinine ziphelile. Ndiyofuna ke ngoku iyeza kuthiwa yimbelesane mandide ndibeleke ke ngoku.

Or if I'm tired of being pregnant and now I've already exceeded my nine months. I will go and ask for a medicinal herb called imbelesane, which will let me give birth immediately.

There was also discussion about women taking a particular herb to support normal delivery of the baby and placenta.

Andiyazi kodwa kuthiwa umntu xa etye laa nto kwenzela ukuba xa ethe wabeleka abeleke kakuhle. Uzakubelekela esibhedlele kodwa kwenziwa kungabikho zinto ezishiyekelayo.

I don't know, but it is said that when someone has eaten that thing, it is usually for giving birth in a normal way. You will give birth at the hospital, but the purpose of the medicine is for the cleansing of the womb so that nothing remains behind.

Another Mentor Mother spoke about a traditional healer turning a baby in breech position:

Ngamanye amaxesha uthathe eza ntsipha zakhona amthi umntu apha ebusweni, uzakuhlukuhla. Uzakumana ekubamba kwezi ndawo (laughs).

At other times he [traditional healer] takes the husks and other solids that remain in the strainer and rubs them in the face and for antenatal care [especially to turn a foetus from the breech presentation to the verticle presentation].

Treating and Healing Children

Babies and children are taken to healers for many ailments, including vomiting, diarrhoea, worms and protection from bad spirits. During my interview with Nolizwe, she explains how she cures worms:

Ndinalo elokuzigoba zingajongisi iintloko phezulu ukuba makayeke ukulunywa.

I have one for bending them so that their heads are not positioned upwards, and to prevent stomach pain.

She adds, slightly animated and pointing her fingers up to the roof of the hut:

Senditsho kaloku xa umntwana etyiwa zintshulube zijonga so. Athi xa ekhohlela ayikhuphe ngasentla. So ke ngoku zithe. Kufuneka zijonge ezantsi ukwenzela xa efumana elayeza lapha esibhedlele zikwazi ukuba ziphume.

When the child has worms they face in this direction and that is the reason when she coughs they come out through the mouth. So that means they are facing upwards. They should face downwards so that when she gets medication from the hospital they can come out.

When I asked her if she treated babies she explained:

Umntana omncinci akanyangeki. Akufuneki mayeza siXhosa kakhulu apha kuye. Hayi akanyangeki umntana omncinci kakhulu. Loo nto sifundiswa ngayo ukuba umntana omncinci akufunekanga umenzele amayeza esiXhosa ngoba usemncinci kwaye amathumbu

A baby is not curable and you shouldn't give them too much traditional medication. No, babies are incurable. We are also taught not to give babies traditional medicines, because they are fragile.

As well as not treating babies, Nolizwe said she did not treat devastating diseases such as HIV/AIDS or TB, and instead referred them to the hospital:

Hayi abakhe bafike. Senditsho andikadilishani nabantu abanjalo qha kuphela ngumntu mhlawumbi okhohlelayo, i-TB le kade ibilula not le inzima, uyakhohlela, abenephika kodwa ndidibanise ukuba ahambe nogqirha, aze kum ahambe esibhedlele.

No, they don't usually come. I have never dealt with such people, except that I usually get people who are coughing, with TB – the curable one and not the drug-resistant one; the person coughs, has shortness of breath, but I make sure that the person sees a doctor as well.

Nosipho did not treat babies suffering from diarrhoea and also referred them to the hospital, but she implied that she could treat someone with HIV if they came to see her in the early stages of the disease. She explains:

Uba ufike engekadleki kakhulu ikhona imbiza endiyiphekayo. Njengalentombazana engikhuluma ngayo ithatha itreatment kodwa yathi yasofika la ngamdliisa imbiza yamklina.

If it has not spread [to the body], there's a herb that I brew. The girl I spoke about takes treatment, but when she came here I gave her the brewed medicinal herb.

Although both these traditional healers showed genuine concern and were aware of the possible dangers of treating babies with Xhosa medicine, it is generally thought that there are traditional healers in the community who do treat young babies, especially for a condition known as “*ipleyiti*” (colic).

Protecting a Family

Traditional healers may also be called upon to protect a family, a homestead, livestock or family members from being attacked by evil spirits. Protection of this kind can also involve the close friends and neighbours of the respective patient/s. Nosipho told me that she was often called upon to “protect families, cattle and children from bad spirits”. According to Dold and Cocks (2012), this form of protection is sometimes referred to as “fastening a house”, and special protective roots are buried at the entrance to the house or kraal (Dold & Cocks, 2012: 51). A common herb growing near many homesteads, called *imphepo*, was pointed out to me by my interpreter one day, and can be gathered by family members or a traditional healer and burned inside a home to keep bad spirits away. *Imphepo* is considered to be a sacred herb, which mediates effective communication with the ancestors during rituals performed to protect a family during difficult periods in their lives (Dold & Cocks, 2012).

Practising Cautionary Measures

These descriptions and interview excerpts above show that traditional healers treat many different illnesses and issues, but take cautionary measures when treating some of their patients. This was particularly evident with regard to treating babies and patients with TB or HIV/AIDS. Nolizwe emphasized that she referred these patients to the hospital, especially if they were coughing. Nosipho, however, felt she was able to help people in the early stages of diseases such as HIV. This is consistent

with the Traditional Health Practitioners Act (Act No. 35 of 2004), which allows for traditional healers to treat HIV/AIDS if they feel they are capable of doing so (Thornton, 2009: 20). Treating babies with Xhosa medicine has been an ongoing concern in Mzingisi, especially amongst biomedical professionals and NGO workers, and has propelled doctors at the hospital and outreach workers from some of the NGOs to discourage local traditional healers from treating babies. This may account for Nolizwe stating that they (traditional healers) had been “taught” not to treat babies with Xhosa medicine. This issue also emerged as a particular concern while conducting a Focus Group with some of the Mentor Mothers outreach workers. One of the outreach workers was visibly angry about traditional healers treating young babies for *ipleyiti* (colic) because she felt that they did not know how strong the medicines were and how they would affect a particular child. She talks with elevated emotion, her fingers stabbing at the table as she states the following:

Kaloku ukha elaa yeza pha ehlathini, akalixilonganga nhe?. So uyalithatha ulinika mna, mna ndilinika loo mntana wam. Uyaqonda akalixilonganga, akalazi ukuba listrongo but uba ndiye pha esibhedlele, ugqirha ulixilongile elaa yeza, uyalazi limfanele loo mntwana and uthi three times a day.

Remember he [the traditional healer] plucks that medicinal herb; he didn't test it, isn't it? So he takes it and gives it to me and I give it to the child. Do you understand that he has not tested it; he doesn't know if it is strong? But if I go to the hospital [I'm sure that the] doctor has tested it and that the medicine is suitable for the child; and he would say that the child should drink it three times a day.

The concern that this worker shows is perhaps a reflection of how successful the doctors at the hospital have been with voicing their concerns regarding the use of Xhosa medicines with babies; but it is also a reflection of the types of issues the outreach workers face when they visit mothers and their babies in their homes. According to the Mentor Mothers, at times the mothers are not receptive to the cautionary messages and may argue with the workers, because they have the living proof of their children who have taken the medicine and are doing well. Two of the Mentor Mothers reiterate what a mother has said to them:

Mhlambi xa uthetha athi abantwana bakhe bonke batye eli yeza lepleyiti. So athi umntu liyamnceda yena ungakwazi ke ngoku uphikise.

Sometimes when you talk, then she would say that all her children have taken this medicine, ipleyiti. So she would say that the medicine helps her and that makes it difficult for you to say something.

Mh-m. Cos uyakubonisa athi, “uyabona, aba balityile. Bakhona. Akafanga.”

Yes, because she shows you and says, “You see these ones have eaten it. They are here and not dead.”

Jansen (1973) recounts from his work as a doctor in a similar community, that the perinatal period was particularly unpredictable and fragile for mothers, who would bring their newborn babies suffering from “i-plate” to him for treatment. He explains that the term “i-plate” originates from the English term “plate” and is associated with the placenta. Elders would examine a mother’s placenta after a birth, and if it displayed a “vascular pattern” they determined that the baby was predisposed to getting “i-plate”, which meant that the baby would have constant stomachaches and would cry a lot. Elders would also predict “i-plate” if a mother complained of stomach aches during pregnancy (Jansen, 1973: 46).

The Mentor Mothers outreach workers are cognizant of the fact that they can do their best to persuade mothers to be careful, but also know that they cannot always influence those who prefer to take their children to a traditional healer.

Traditional Healers and Christianity

Both the traditional healers I interviewed held important positions within their respective churches. Nolizwe served as a priest in the Zionist church, and Nosipho described herself as a leader in her church, but could not tell me the name of her church in English. She emphasized that she was a Christian and a diviner, which probably accounts for the satin “cross” sewn on the back of the cloak she wore during divination. However, when I asked her how the churches in the community

responded to traditional healers, she replied: “*ziyasicaphukela*” (they hate us); but she added:

Kodwa ebusuku bayachwechwa beza kuti.

But they come quietly to us at night.

Dold and Cocks (2012) confirm that *amagqirha* (diviners) usually serve both as healers and as priests, and are often believed to have “supernatural” powers. Robert Thornton (2009) also affirms that most diviners/*sangomas* are active in Christian churches and may also be faith healers. Although many of the diviners also practise their Christian faith, they are well aware of the tensions that exist between their healing practices and the more conservative churches that do not outwardly support their healing practices.

Tensions between the Church and Traditional Healing Practices

Nolizwe’s statements indicate that people may be influenced by their religious or spiritual beliefs when it comes to choosing their methods of health care and getting treated for illness. There appeared to be a strong Christian presence dominating many aspects of the social structure in Mzingisi – from the church services conducted at the Dutch Reformed Church twice a week in the centre of the village, to the throngs of people on Sunday mornings making their way to various churches, prayer books in hand, or the Wednesday morning church service in the hospital OPD, led by the nurses or one of the doctors. There were also the Church Council women dressed in black skirts and white blouses and closed-toe shoes getting rides to their meetings on Thursday afternoons, and the daily early morning “wake-up” call of bass-thumping gospel music that blasted from the “Pink House”, a hair-shop-cum-restaurant-cum-movie-theatre, that entertained bored teenagers after school for half the night.

During my encounters within the community, I noticed that many people adhered to customary values and beliefs, while at the same time valuing teachings from the

church. Many of the people I interacted with attended church, preached from the Bible, and openly shared their strong Christian beliefs. Prayers were said at every public gathering and before meetings, or eating, and references were made to God or “Our Heavenly Father” in conversations, especially between elders. If I dropped in to greet Mama Mfundisi (the Pastor’s wife) in her sewing hut, or at her house (known as the Mission), she always asked me to pray with her. While all this seemed to be the norm, so too was the practice of making *Umnqombothi* (traditional beer) to appease ancestors, or the belief that if a person was struck by lightning (a fairly frequent occurrence), it was caused by the wrath of their ancestors.

Some of the tensions that exist between the more conservative churches and traditional healers could be because the churches view traditional healing in the same context as “witchcraft”, which is perhaps a residual view from the colonial era, much like the first settlers and missionaries had when churches across the rural Eastern Cape were first established. This view may be amplified for members of church councils, or for people who hold other leadership positions within their respective churches. This may have been the case when I asked one young woman whether she had ever gone to see a traditional healer, and was met with vehement denial. She said that she was a Christian and did not believe in traditional healing, stating: “I pray to my God and Father; I do not need a traditional healer.” This response was particularly intriguing, as several informants had alleged that she had received treatment for infertility, including from one of the diviners I had interviewed. The diviner pointed her out as someone to whom she had given Xhosa medicine so that she could fall pregnant. But it is also plausible that because I, an outsider, was interviewing the young woman, she felt that she should tell me what she perceived I wanted to hear from her, rather than what may have been her actual experience.

While Mndende (n.d.) emphasizes that a diviner’s duty is to heal and not harm his or her patients, and that ancestors’ intentions are never to harm, because it would upset the harmony and balance in the spiritual world, there were times when

“unexplained phenomena” occurred and the whispered speculation was that “bad” people from outside were involved in things like “witchcraft”. One such occurrence happened when a man in the community had a sheep stolen one night, which was later found with just its entrails cut out of it. Later that same week, a young man had been invited into someone’s home to “eat meat”, only to discover that they were eating only “offal”, which is usually reserved for women to eat at rituals and ceremonies. The young man reported this and the incident were resolved because the sheep-owner went to see the people involved and demanded compensation. On another occasion, a woman found one of her sheep outside her homestead with its stomach cut open.

Cultivating Health and Well-being through Traditional Healing Methods

From the descriptions in the sections above, it becomes apparent that many people in the Mzingisi community choose traditional healing practices as a way of treating their illnesses and maintaining their health and well-being. Specifically, women visit diviners and seek treatment for themselves or their children, especially when they feel that the illness cannot be treated with biomedicine. The descriptions also show that traditional healers/diviners (*amagqirha*) treat patients through a variety of practices, guided by the knowledge of their ancestors and the Supreme Being, with the intention of restoring the patient’s health and well-being. Although some people are influenced by their Christian beliefs, they also maintain their relationships with their ancestors, and so seek healing via the knowledge and expertise of a traditional healer.

Reproducing Knowledge and Skills

Ancestors’ Knowledge

In order for diviners to practise their profession, they are reliant on the expertise and knowledge of their ancestors and must maintain an ongoing relationship with them to be able to do their work. Ancestors provide the pathway for the healer to access information about a patient’s condition and the appropriate method for

treatment. Because ancestors are said to act as the intermediaries between the Supreme Being and the diviner, their knowledge could be interpreted as coming directly from God, or as being divine. As such, diviners accept that the knowledge and insights they receive during divination regarding diagnosis is correct. Ancestors can inform the healer that a prospective patient will be visiting him or her for a diagnosis of a specific illness on a certain day (Sodi, 2009). This was illustrated when Nosipho said the following:

Uyabona lo uzofika ndipheka iyeza lakhe.

I am brewing the medicine of the one who is coming.

Diviner's Knowledge

A diviner's knowledge about healing is developed through a period of supervised and guided training (*ukuthwasa*) from a master healer and teacher. The healer-in-training (*umkhwetha*) is required to develop his or her psychic abilities and/or develop open and sanctioned channels to the ancestors so that divine knowledge can be received during divination. Once the healer has acquired enough knowledge to be able to work without a teacher, the ancestors show the trainee, through a dream, where to find the cow that he or she is required to slaughter to signify the final stage and completion of the training period. The *itshoba* (cow's tail) not only proves that the healer has completed her training, but is a sacred and specialized tool that mediates during divination (Mndende, 2006).

Traditional healers develop their skills and knowledge through a process of what Lave terms "legitimate peripheral participation" (Lave, 1991: 68) within a community of practice of traditional healing. Here, the trainee learns from master diviners until she has gained enough knowledge to "become" a healer herself, moving from peripheral participation to full participation as a trained traditional healer (Lave, 1991: 68).

Multiple Healing Practices in a Changing World

While this research focuses on exploring indigenous practices surrounding health and well-being, it became evident that these practices are not isolated or static, fixed in time and space. The indigenous health practices in the Mzingisi community are carried out against the backdrop of a dynamic and changing culture, which holds within it all the complexities of modernity and the global influences that are woven into the social fabric of community life. Hence, many people incorporate both traditional healing and biomedical (“Western”) healing into their lives.

In the next section of this chapter, I will describe some of the biomedical practices that are used to treat women in the Mzingisi community. These descriptions are drawn from my observations in the OPD, some of the hospital wards and the operating theatre, as well as from field notes and informal conversations with medical professionals working at the hospital.

Biomedical Health Practices

The health care services at Mzingisi hospital include outpatient care, antenatal and postnatal maternity care, and deliveries. There are also general wards for women and men, a maternity ward, a paediatric ward and a TB block. The outpatient department provides emergency care 24 hours per day. An operating theatre provides services for caesarean sections as well as other minor surgeries (Hospital website). There is also a helicopter-pad for emergency medical evacuation to a better equipped hospital in East London, and it is used quite regularly for maternity emergencies and for babies and young children in critical condition. Mzingisi hospital also supports 13 clinics in the surrounding and outlying communities, where ARVs are delivered on a bi-monthly basis. There is a clinical team of approximately 24 medical professionals and 120 nurses as well as several physiotherapists, occupational therapists, a speech therapist and a dentist (Hospital website). From some informal conversations with some of the doctors, I gathered that nurses are ranked according to their seniority and specializations such as

paediatrics, the operating theatre, orthopaedics, maternity, etc. From my observations and informal conversations, I found that NGO volunteers, the doctors and rehabilitation professionals generally work normal business hours, Monday through Friday; however, nurses work 12-hour shifts during the night, or daytime, and are on seven-day rotations. This allows nurses living outside of the community to travel the long distances at the end of their seven-day shift, to be with their families. Doctors also rotate on-call shifts throughout the week after hours, and throughout the weekends.

Biomedical Diagnoses and Treatment

Mzingisi hospital is a hub of energy abuzz with people, patients and medical staff. On most days, the OPD is filled with people waiting to see a doctor for diagnosis and treatment, and the corridor leading to the doctors' offices is often so crowded with people, it is hard to get through without having to carefully navigate around the mass of people. There are mothers holding their sick babies or young children, and people sitting or lying on the benches waiting to be seen. The following is an excerpt from my field notes:

Although the waiting room in OPD was full, people seemed to be in good spirits and didn't hesitate to greet me or smile as I walked through. There was a typical antiseptic odour that hits your nostrils as soon as you enter through the door. Inside, the corridor outside the doctors' offices is lined with sick patients, some of whom are attached to IVs. It is particularly hard to see a mama with a tiny baby attached to a drip in her arms. One knows that these babies are on a delicate path for survival. On the other side of the fence outside the hospital, there are women selling fruit, biscuits, chips, cool drinks and amasi (buttermilk) and loaves of bread, as well as all kinds of sundries like soap, sponges, washcloths, etc. There are also full-on catering units with women cooking popular foods such as chicken feet, ngqusho, rice, vegetables and of course the staple, amagwenya (fat cake) and polony. There are also two horses waiting and grazing outside the gate.

According to one of the doctors, they usually see an average of 100 to 150 patients a day for various diagnoses and treatments. Throughout the day, outside the OPD, people can be seen sitting at the concrete picnic tables waiting to see family members or taking a break from the long wait inside. Because this is the only hospital within hundreds of square miles, people will travel several hours by taxi and wait all day to see a doctor. If a patient is admitted, family members will “camp” at the hospital in OPD or find someone to stay with until the patient is discharged. If a child is admitted into the paediatric ward, mothers or a close relative will usually stay in the ward with the child. While visiting the paediatric ward I observed that almost every child had an adult sitting or sleeping on the bed with them or on a chair next to their bed.

Antiretroviral Treatments (ARTs)

In 2003, the South African Department of Health embarked on a comprehensive programme for the care, management and treatment of people diagnosed with HIV (Leigh, 2012). Between 2004 and 2011, it was estimated via statistics obtained from the South African Department of Health and data taken from NGO and private sector surveys, that the number of patients receiving ART across the country increased from 47,500 to 1.79 million: 85% received ART through the public health sector, 11% through the private sector, and 4% through NGO community outreach programmes (Leigh, 2011: 23). In 2011, it was estimated that there were 187,000 patients being treated with ARVs in South Africa, a larger increase from the 5,300 being treated in 2004 (Leigh, 2012).

According to an NGO volunteer I interviewed, who worked in the hospital’s ARV programme, Mzingisi hospital began operating an ARV down-referral programme in 2010 to two clinics in the area, and had increased to 10 clinics serving an average of 900 patients in 2011. It also operates an ARV clinic on the hospital grounds and houses an NGO programme dedicated to ARV management. The down-referral programme consists of providing pre-packaged ARVs to patients on a monthly basis,

as well as keeping track of data such as weight, blood analyses and CD4 counts. Senior nurses are responsible for dispensing ARVs to patients and educating them on dosages, as well as taking blood samples when necessary. The ARV clinic at the hospital serves patients who need to see a doctor on a monthly basis, such as those who have just begun treatment, pregnant women, children, those who have had weight losses (one of the indicators for having TB), and those who are changing treatment plans (NGO volunteer, 2011).

Maternity Health Care

Mzingisi hospital provides maternity services to approximately 1,800 mothers each year (Dr. Gwen, 2012). Women stay in the maternity ward if they are due to give birth, or after they have delivered their babies. Some women stay because of antenatal or postnatal conditions that require prolonged medical care. Others because they gave birth via caesarean section and need extended time in hospital to heal. There is also risk of infection. Following is a description of my observations taken from my field notes while accompanying one of the doctors (Dr. Gwen) on one of her rounds in the maternity ward:

It is a Sunday and the hospital is fairly quiet. The maternity wing occupies the newest part of the hospital and is painted in pinks and greys. On entry, there is a notice emphasizing the need for breastfeeding, with posters from the Dept. of Health on most of the walls. There is a senior nurse and midwife on duty. There are several wards: postnatal, antenatal, two observation and delivery wards, a post-caesarean ward, two post-deliveries and one labour.

We enter the first postnatal ward. The senior nurse translates for the doctor because she does not speak isiXhosa. Dr. Gwen is checking the patients one by one – there are six beds in the ward and each bed is decked with pink flannel sheets with yellow teddy bears on them. There is a TV up on the wall showing breastfeeding infomercials, but it has the volume turned down so as not to disturb the moms and their new babies. There is a sink, a hazardous waste bin and an ordinary rubbish bin at the far end of the ward. Most patients have a roll of toilet paper on their bedside table – they have to supply their own. There is a doctor's trolley, which is rolled into to each ward, containing rubber gloves, syringes, swabs, a tape measure, speculums and some other things that I cannot identify. There is a notebook hanging at the end of each patient's bed. The doctor writes in each one after attending to the patient as well as in the general notebook on the trolley. I follow the doctor and nurse around the ward but keep my distance so as not to be too intrusive. Dr. Gwen tells the patients who I am and why I

am there. The nurse translates and is very friendly with all the patients – as is the doctor.

The first patient has no pains and is told she may go home. The second patient has a baby and is breastfeeding. The doctor says she will do an ultrasound to check on the mother's condition. The third patient was sick during post-partum and is recovering and requires help with washing herself. The fourth patient's baby apparently has not peed or pooped yet and is two days old. The baby seems fine – the doctor checks the baby thoroughly – all vital signs are good, so she is not worried. She says the baby is not in pain and will eventually urinate. The fifth patient says that she is "much better" and that she is healthy now. She apparently had an infection after a caesarean. The doctor draws the curtains around her bed to check her wound area. She tells the nurse to continue irrigation of the wound. The sixth patient had a breast abscess and apparently did not come to the hospital for two months! She still has enough milk to feed the baby from her other breast. The doctor tells her she should stay another week until the wound is completely healed. The sister dresses the wound. One of the new mothers from across the ward holds her baby for her while Dr. Gwen attends to her wound. Before we leave, the doctor emphasizes the need for continued and frequent hand-washing by all patients, especially as there are so many babies around.

In the next ward, a mother had delivered her baby in the Waiting Mothers Rondavel, and it is noted as a BBA (Birth Before Arrival). A senior assistant helped her. This is the mother's fourth baby. She tells the doctor she doesn't want any more children. She already has two boys and two girls, and asks if she can be sterilized. The doctor says she can do it the next afternoon, and tells the patient that she must not eat after breakfast. The doctor adds that the mother must sign a consent form for the sterilization procedure. The doctor examines the baby; he is fine and a big baby.

The above description shows that there is a high quality of care provided within the maternity ward, both by the presiding doctor and by the nurses on duty. Medical treatment is administered to treat various postnatal issues such as infections, abscesses and post C-sections. It is necessary for the patients to stay at the hospital, because they are receiving ongoing treatments that need to be monitored by the doctor and nurses.

While conducting this research, Dr. Gwen suggested that I observe her doing a C-section some time. I was a little hesitant and thought about how the patient might feel having some stranger watching while she had her baby. The opportunity arose one afternoon, while I was on my way to arrange for an interview. Dr. Gwen called me on the phone asking me if I wanted to join her, as she was going to be doing a C-

section in 15 minutes. I was delighted as this was a side of health care that I had never experienced before and yet seemed to be a common procedure experienced by many pregnant women in this community. The following is a description from my observations recorded in my field notes afterwards.

I rushed to the operating theatre and went into the changing room to put on my scrubs and head cover. When I entered the theatre, Dr Gwen was already preparing the patient – giving her the spinal block medication.¹⁵ The patient was sitting on the table. She looked young and tired. Apparently she was exhausted from being in labour for 24 hours, and was not dilating quickly enough. She was also HIV positive and earlier had been given a labour enhancer, which had not really helped, but meant the baby needed to be delivered within 5 to 6 hours after the enhancer was given. The baby was not in distress and was quite large, and Dr. Gwen said that having a C-section was the safest option.

I stood and waited while the block was being administered. The mother had given her consent for me to be there and I checked again before the procedure began. The operating theatre was quite active, with two nurses preparing for the procedure and the doctor giving the block. One nurse was talking to the mom and asking her to sit appropriately for the anaesthetic block needle to be inserted. Then after it was administered the nurse had the mom lie down and she and Dr. Gwen put the blood pressure and temperature monitors on and attached them to the mom's fingers. The screen was beeping and the temperature graph was showing. The IV drip was changed and things looked like they were soon to begin. There were no foetal monitors! I wondered about that and had asked the doctor about it earlier. She explained to me that operating a foetal monitor required very precise knowledge and that it would be great to have them, but the nurses would have to have extensive training and then have someone in charge monitoring and overseeing them. One of the nurses started to drape the green sheets over the mom and over the metal bar that blocked her view from the procedure. Dr. Gwen began to spray water on the mom's legs, thighs and abdomen to see if she could feel anything. She also sprayed her on the chest to see how much she could feel there. The mom said she could not feel anything, which is considered dangerous because if a patient cannot feel anything in her chest then it is possible for her to stop breathing and go into cardiac arrest! Dr. Gwen took precautions and called in another doctor to sit with the patient and monitor her breathing. The nurse began swabbing iodine all over her stomach and along and above the pubic bone.

Then Dr. Gwen made an incision about 6 or 7 cm long, first through the skin and then through several more layers. The fat is the thickest layer and is yellow in colour – much like chicken fat. The doctor then tore through the layers – this looks horrible, but is supposedly a more beneficial way of doing it than cutting the entire area, as it heals

¹⁵ Spinal and epidural anesthesia are medicines that numb parts of your body to block pain. They are given through injection in or around the spine (www.nlm.nih.gov/medlineplus).

better and less scar tissue forms. So “rip, rip”, and then she showed us the uterus – a grey shiny surface inside the cavity. She then cut through it and opened it up. It was all quite awesome. The nurse then passed a metal “spatula-type” instrument to the doctor and this was used to pry open the area and hold it open. It looked like the doctor then pulled and twisted something inside the cavity, and then the baby’s head emerged, then an arm and then the whole body, quite miraculous! The nurse took the baby and wrapped it in a blanket, and asked the mom if she was ready for her baby. Dr. Gwen also pulled out the placenta and asked the nurse to swab out the area. The placenta looked small and seemed a bit thin, but the baby was big and healthy. After clamping and cutting the umbilical cord, the baby was shown to the mom. Then it was given an APGAR¹⁶ test (checked for reflexes, etc.). The nurse did not weigh the baby, but they all said it was a big baby. Doctor Gwen was in high spirits and congratulated the mom and made joyful exclamations, smiling and cheering the mom. Then she went about stitching her up. She pushed down the uterus and swabbed it to get all the blood out and to stop the bleeding, which was not that much. (If the bleeding is not stopped, then infection can set in.) She then began stitching in three layers: first the uterus and then the fat layer, and finally, the skin. Because the mom was HIV positive, the doctor stitched intermittently, meaning that each stitch is done individually and tied off. This is a precautionary measure so that if there is an infection it is easier to re-open the area so that the infection can be attended to. After stitching, the area was covered with gauze and a big plaster.

The patient was then moved onto a clean sheet and the one she had been on was placed in a bin. The placenta was tagged and placed in a basin on the lower shelf of a trolley. The IV bag was replaced and soon the patient was wheeled out to the recovery area. The baby was taken to the nursery and would be given to the mother when she came out of recovery.

At this point, it was time to leave and I went to change out of the scrubs. Dr. Gwen and I talked about the amazing procedure. She claimed to have done several hundred caesareans, but the difference here at Mzingisi was that the doctors had to do the procedure on their own, including the epidural (anaesthetic block for lower abdominal area), unless there was a risk of complications such as a mother delivering twins, or her having little feeling above the abdomen after the block was administered. In these cases, another doctor would assist, as was the case with the caesarean I had just witnessed.

¹⁶ APGAR tests the baby's breathing effort, heart rate, muscle tone, reflexes and skin colour at one minute after birth, to determine how well the baby tolerated the birth process, and at five minutes after birth to see how well the baby is doing outside the mother's womb (www.nim.nih.gov/medilineplus).

ARV Interventions

The administering of ART in Mzingisi and outlying communities has had a huge impact on people living with HIV. HIV counsellors at the ARV clinic at Mzingisi hospital and outreach education through one of the NGOs have helped to transform the notion of HIV/AIDS as being a “Killer” disease, to a disease that can be treated and that people can live with. Not only are many people managing their illness and living relatively healthy lives, the stigma around HIV/AIDS has also decreased. According to an ARV counsellor, many young people, particularly women, speak openly to one another about taking their ARVs and knowing their status. They also have the added hope of a long life expectancy. Recently, one of the NGOs affiliated with Mzingisi hospital stated in their newsletter that there were 3,795 HIV patients receiving ARVs every month at a clinic of their choice (NGO newsletter, 2013).

Mothers with HIV who give birth at the hospital are given Nevirapine (NVP) to counteract infecting their babies during birth, and are encouraged to breastfeed exclusively for six months to help reduce the possibility of mother to child transmission (MTCT). Additionally, NGO outreach workers visit the maternity and paediatric wards twice a week to educate new mothers and women about the benefits of exclusive breastfeeding, including mothers who are HIV positive.

Making Choices about Health Care

The above descriptions of traditional healing and biomedical health care practices show that women access a variety of health resources available to them and their children. The descriptions also show that there are two distinctly different systems of healing available. When faced with illness, pregnancy or childbirth, or when looking for ways to restore balance in their lives, women seek care from one of the traditional healers in the community, or from doctors and medical professionals at one of the clinics or at Mzingisi hospital. In most instances, illnesses and conditions that cannot be treated with biomedicine, such as being a victim of bad luck or illnesses caused by evil spirits, are treated by a traditional healer, whereas

biomedical services are sought for chronic illnesses, maternity services and acute physical ailments and injuries that require the care of a medical doctor. Most women in the community choose to have their babies at the hospital, although it is estimated that approximately 25% still have their babies at home (Gaunt, 2010).

Reducing Tensions between Two Healing Modalities

In Mzingisi, there are several choices for taking care of one's health and well-being. On the one hand, there are traditional healers who provide healing that they and their patients believe cannot be healed through biomedicine. Traditional healers utilize a holistic approach and access a diagnosis and treatment through the ancestors and supernatural forces. Biomedical practitioners, on the other hand, aim to treat most medical and health issues within the capacity of the medical facility, and often believe that traditional healing practices are inadequate. This has caused tensions between the two health care systems, although attempts are sometimes made by doctors to understand the perspective of traditional healers.

Within the biomedical system, efforts are made to provide treatment and education to the patients who visit the hospital and clinics. When necessary, patients are admitted to the hospital for acute illnesses or conditions such as infections and long-term treatments, which was illustrated by the earlier descriptions of patients and types of care they received in the maternity ward and in the operating theatre.

During my fieldwork, I attended a meeting where two visiting medical students presented their data regarding traditional healers in the immediate community and a healer from a nearby town in the district, who apparently was notorious for prescribing Xhosa medicine to young babies and allegedly poisoning them, resulting in their deaths. In the interview we viewed on DVD, this traditional healer stated that she had been practising for over forty years and that she mainly had successes with her treatments, and that no one had ever blamed her for the deaths of their children. In the discussion afterwards, some doctors were intrigued by her

statements and considered that perhaps parents did not perceive that the traditional healer had caused the death of the child, but instead saw it as the failure of the hospital. This would be consistent with what Jansen (1973) interpreted as Xhosa medicine failing to provide follow-up treatments or consultations for patients, meaning that if the Xhosa medicine failed to cure a patient, another diviner would be consulted for further diagnosis rather than going back to the first one for follow-up.

I would also suspect that it is possible that some parents consider various causes for the death of their child, depending on their spiritual values and belief systems. If illness is viewed as being a teleological phenomenon, then causes such as witchcraft or the wrath of the ancestors might be considered and no specific person would be identified or blamed for causing the death. In the realm of possible causes, the parents could feel that the traditional healer had done her best to beat the odds by diagnosing and prescribing Xhosa medicines, and the doctors at the hospital had also done their best to save their child. However, in viewing their bad luck or misfortune as being caused by the wrath of the ancestors or by supernatural forces, they might also believe that efforts still needed to be made to prevent future misfortune, because the ancestors ultimately have the power to transcend death and misfortune (Dold & Cocks, 2012; Mndende, 2006; Thornton, 2009).

Recognition of Traditional Healers

During my fieldwork, I attended a meeting of traditional healers, in collaboration with an occupational therapist from the hospital. Under discussion were issues of existing tensions and attempted collaboration with the hospital, noting that doctors did not refer patients to the traditional healers, although the traditional healers did refer patients to the hospital. Also under discussion were issues surrounding the new government initiative to register all traditional healers with the National Association of Traditional Healers so that there would be documentation of those who are practising, their category of expertise, as well as monitoring of them. The

traditional healers from the community attending the meeting were not all in favour of this initiative, as is also the case in other parts of the nation (Thornton, 2009). However, according to Levine (2013), some traditional healers in the Western Cape were not only eager to be recognized for their profession, but were also eager to become certified traditional healers, as proposed by the Department of Health, when they drafted a national traditional healers' exam in 2007, which, on passing, would allow them to practise in the public health sector (Levine, 2013: 62). Furthermore, those traditional healers were also excited about the prospect of having access to further education, such as in the University of Witwatersrand School of Medicine's Bachelor's and Master's degree programmes in indigenous knowledge systems, which were created to help legitimize traditional healing and indigenous knowledge practices (Levine, 2013: 60).

Collaboration between biomedicine and traditional healing may seem limited, but other efforts have been made to bridge the gap. An example of this is a project spearheaded by Jo Thobeka Wreford (2006), in collaboration with the HIV Outreach Programme and Education (HOPE), who began an innovative project to help bridge the gap between biomedical practitioners and traditional healers, specifically around the issue of HIV/AIDS in the Western Cape. The project also aimed to educate traditional healers about HIV/AIDS and possible disruptions to patients' ARV regimens caused by traditional Xhosa medicines interfering with them, and to educate biomedical doctors on the practices of traditional healers, thus engaging in "bilateral" learning. The programme was successful because it acknowledged that traditional healers were professionals, and exposed biomedical practitioners to some of the ways in which traditional healers perceive and treat illness (Wreford, Hippler & Esser, 2006).

The World Health Organization (WHO) spearheaded international recognition of traditional healers as health care providers across the world, in 1975. The Executive Board called for research and training programmes to help improve the services of indigenous healers and to help integrate them with primary health care systems

(Sodi, 2009). In 2008, the WHO, having concluded that approximately 80% of people living in Africa used the services of traditional healers, began an initiative with member states, to acknowledge traditional healing as primary health care and to help improve collaboration between biomedicine and traditional healing modalities. In South Africa, there are an estimated 180,000 traditional healers and approximately 27 million people who utilize traditional healing for their health and well-being (Levine, 2013).

Conclusion

The descriptions and discussions in this chapter have shown that:

- (a) Women express their agency strongly and make choices about how to take care of themselves and their children.
- (b) There are many factors influencing the ways in which women in the community take care of their health and well-being.

Influencing factors stem from the reputation of the hospital and the successes it has had with biomedical interventions, especially around childbirth and HIV management, to spiritual and religious beliefs, to macro influences such as access to social media and modern trends. It is evident that many women utilize both biomedical healing and traditional healing systems, although the choices they make about which system to use are based on their individual and collective needs. Traditional healers tend to treat illnesses that cannot be treated with biomedicine, while doctors tend to treat illness and conditions that require biomedical interventions and technologies that are outside the realm of traditional healing. There were also indications that at times there were tensions between the two systems of healing, which sometimes impacted choices women made about seeking treatment for their children.

CHAPTER SIX

CHILDREARING AND SOCIALIZATION

Introduction

In the previous chapter, I described and discussed different types of health practices and the different options women have surrounding the cultivation and maintenance of their well-being.

In this chapter, I will describe some of the childbirth, childrearing and socialization practices that are present in the Mzingisi community. I will draw from my observations, informal conversations, field notes and semi-structured interviews. In the first section of the chapter, I describe pregnancy and childbirth practices in the community. This is followed by a description and analytical discussion of some of the major issues surrounding teenage pregnancy. Lastly, I describe some of the childrearing practices and how the changing social structure has shifted some of those practices

Pregnancy and Childbirth

The Value of Children

As with most communities children are highly valued, and young married women are usually eager to become pregnant and have their first child soon after they are married. If women have difficulty in becoming pregnant, they may visit a traditional healer for treatment. Both of the traditional healers I interviewed said they had treated women in the community in order for them to conceive, and that becoming pregnant was a common issue for which women sought help. While I was not immediately aware of any overt stigma attached to women who could not conceive, I would suspect that there is a certain amount shown towards women who are perceived to be “barren”, hence the urgency for young women to conceive so soon

after being married and for brides to undergo ritual cleansings so that they are able to have children, as was described in Chapter Four. From my observations, it was evident that many women have children with their partners before they are married, which I have been told by various women, in informal conversations, is often to prove that they are fertile and therefore “valuable” to the family and clan. This is consistent with Jewkes, Morrell and Christofides (2009), who argued that some young women and teenagers are encouraged to become pregnant because babies are highly valued and infertility is considered a serious issue. Likewise, data gathered by Lipkova and Leon (2012) found that several young women they interviewed in the Mzingisi community and surrounding areas admitted to visiting a traditional healer so that they could get pregnant. Having children before a couple marries can also be due to economic issues, when they cannot afford to get married and the husband-to-be is still saving for *lobola*. This was confirmed by some of the doctors at the hospital and by some women I chatted with informally, as well as some of the outreach workers in the community.

As much as children are valued, there is still a need to control the size of one’s family and mothers who have several children often ask to be sterilized at the hospital shortly after the birth of the child they consider to be their last. In my encounters with women in the community, several had mentioned getting sterilized after their last child. One mother, who I chatted with regularly and who worked for an NGO, had arranged to be sterilized a week after her fifth child had been born. She also shared with me her fear of having the procedure done, but knew intellectually that it was necessary. According to one of the doctors, it is standard practice in the maternity ward to ask mothers who have several children if they want to be sterilized. While I was on a maternity ward rounds with one of the doctors, a mother asked if she could be sterilized, so the doctor arranged for the procedure to be done the next afternoon.

It is evident from these informal conversations and my observations that it is of cultural importance for women to bear and raise children and/or large families. But

what is also evident is the underlying notion that women need to be fertile to be of any value as a partner or wife. An impact of this is that women may feel pressured, both by their partners and by the social expectations embedded within their community, to become pregnant and have children at an early age or early on in their marriage. If they have difficulty conceiving, they may seek help from traditional healers, often in secret (due to tensions between Christian, biomedical and traditional values), so that they can prove to their partners or spouses and in-laws that they are capable of becoming pregnant and therefore have value as a woman and a wife.

Home Births

Many babies in the community are born at the local hospital, but it is estimated that as many as 25% of babies are still born at home (Gaunt, 2010). When I asked around the community about mothers giving birth at home, all the women I spoke with stressed that most women prefer to give birth at the hospital, but sometimes do not get there in time, or give birth on the way to the hospital. This is often due to the long distances women live from the hospital and the lack of adequate transportation. When I inquired about the prevalence of midwives in the community, most women told me there aren't any, which I assumed to mean that there are not any "formally trained" birth attendants. However, my feeling was that there are women in the community who are skilled birth attendants or midwives, known as *ababelikisi*. My thinking is supported by the fact that women who do intend to give birth at the hospital, but end up delivering at home, or women who have no choice because of distance from the hospital, are helped by a woman or women who live on, or within close proximity to, their homesteads. And the women who help the mothers give birth, particularly elders, do have the skills and know what to do when a mother delivers her child at home, as will be shown below.

In the past, it was customary for new mothers to be cared for by the midwives or *ababelikisi* during the delivery and post-delivery stages, when customarily the

mother was secluded from her family and community. Doctors at the hospital spoke of women giving birth at home and then bringing their newborn baby to the clinic to be checked afterwards, and also of women who delivered their babies before they arrived at the hospital and are recorded as Born Before Arrival (BBA). While I was on a maternity ward round with one of the doctors at the hospital, two babies were reported and recorded as being BBA because they had been born before the mother was able to get to the hospital to deliver. This was also confirmed during informal conversations and interview sessions with some local women.

In an informal conversation with Zenzi, a woman in her late forties and a mother of six, I was told how she had given birth to her fourth child at home by accident. She explained that she had felt no labour pains and that she was caught at home. She had called out to some women nearby to help and they came running to her house, took off their *doeks* (head wraps) and put them on the floor as a place for the baby to land. She said:

The woman just yelled: “take off your clothes”, and then the baby just came, just like that. Then they lifted him out of the sac he was still inside. Then they just cut the cord with a piece of sharpened stick.

She added that there were always women during her mother’s time who knew about childbirth. She said:

They would just call everyone around when it was close to when a woman was giving birth. The men would sit over by the Kraal together, and the women would sit outside the hut and they would chant, “give birth, give birth”, until the time when the baby came, and somehow they knew when it was coming; they threw down their *doeks* and then the baby would just come. There was one woman who would sharpen a stick ready to cut the cord and they would wrap it until it was ready to fall off.

In a group interview session, Faseka, a mother of five and in her fifties told me about her experience of giving birth at home. She had three of her children at home and two in the hospital. She explained that before you give birth, a pregnant woman is expected to collect the wood to build *igoqo*, which is wood needed to make the fire for heating water for the birth, etc. After giving birth, the birth attendant cuts the

cord with a razor and places a matchstick in the cord. The mother is not permitted to get up until the baby's cord falls off. During this time, women in the village collect water and cook for the new mother. When the baby's cord falls off, the women who are assisting will spread new dung and clean the whole house and open the windows to show that the child's cord has fallen off. After that they prepare the traditional medicine they believe is going to help the child.

Ekhaya abantu ababendinceda ngumama. Bendiye ndibeleke ndisagqiba athathe la mhlaba noba sistena kuqalwe kusikwe laa nto ubuthetha ngayo. Bathi ke mandenze ngokwam, mandigube.

The person who helped me at home was my mother. I would give birth and when I'm done, she would take the soil or a brick and grind the thing [cord] you were talking about. So they said I should grind it on my own.

Uyangceba. Kuthiwa kukunceba.

They call that process of grinding the cord "ukungceba".

She continues and says that when she delivered one of her babies at home her intention had been to have her baby at the hospital. There was no ambulance at the time to take her to the hospital and while she waited for a nurse to come she gave birth to her child. When the nurse did arrive, she came unprepared. She explains:

Omnye ke umntana kwajika i-ambulens. Phofu zange ijike i-ambulens. Ndandiphangela komnye usisi omhlophe. So ke ngoku umama wacela omnye umakhelwane ukuba aye phaya emsebenzini boxelela laa sisi ukuba ndisesibhedlele. Weza ke la sisi. Inoba weza phaa ngo4 ekuseni ngemoto wafika. Waya esibhedlele wabe endishiya caba wayengafuni ukundisa ngokwakhe engeyonesi. Wayothatha i-ambulens. Caba i-ambulens ayikho. Weza ke apha ekhaya nenesi. Xa ifika apha le nesi ekhaya, sendibelekile ke ngoku. Hayi kewafuneka yenze ezi zinto zakhona. Caba ipleyiti uyilibele. Eyokuqala umntu opregant kufuneka abeneblade entsha, soloko eyibekile. Zonke izinto zibe lapha, irhali. Ndathi kuba loo sisi engenayo, ndamnika ezam wabe sethatha endenza. Kwaba kuphelile ke ngoku kuye. Ndabe ndigqibile. Omnye ke ndambeleka kakuhle.

With the other child, the ambulance had to turn away, but it did not turn. I was employed by another white lady. So my mother asked someone to tell my employer that I'm at the hospital. This lady [my employer] then came. I think she came around 4 a.m. by car. She went to the hospital and left me at home

because she didn't want to drive me to the hospital knowing that she's not a nurse. She went to fetch the ambulance, but there were no ambulances. So she came back to my home with a nurse. When they arrived it turned out that the nurse had forgotten the tray [with equipment] in the hospital and she had to perform her nurse duties. The first important thing that a pregnant person should have is a blade. Everything should be here including a cotton thread. So I gave my equipment to the nurse since she didn't have hers, and she started doing her job. Then I was done. The other ones' [births] went well.

Another woman, Nomvula, also in her fifties and a mother of seven, had one of her children at home and one while being transported to the hospital. She told me in an interview about having her baby at home:

Mna njengokuba ndilunywa, ndacela umntana makabize loo mama ndisenzela kubekho umntu njeba ndilunywa. Ndihlala nabantwana ukwenzela kubekho umntu omdala. Ngoku ndisahleli loo mama wazama umntu ongubhuti wasemzini wakhe ukuba makazobiza i-ambulensi. Esathi uyahamba wavela weza umntana. Akukho nto wandinceda ngayo. Mna ndavela ndazibelekela. Xa uncedwa ngumntu uthatha umhlaba qha uqushwe la mkhaba uphele uyitywe ubezipisi uhambe uyolahwa ehlathini.

When I was in labour, I asked a child to go and call for that old woman so that I could have someone. I only live with children, so I wanted to be with an older person. While I was seated, this woman asked for her brother in-law to call an ambulance. When she went out, the baby came out. She didn't help me with anything. I just gave birth on my own. When someone helps you, you take soil and grind that cord until it becomes fine; and then throw it in the forest.

As described by Zenzi, Faseka and Nomvula, there are women, especially elders, present in the Mzingisi community, who have the skills and knowledge to help a pregnant mother deliver her baby and provide the necessary postnatal care for the mother and child. What becomes clear is that this knowledge has been reproduced within the collective community of women over several generations. Much of the knowledge is based on knowing how to access resources from the natural environment such as specific tools, herbs and foods. The women who had given birth expressed that it had not been their intention to have their babies at home and they had planned to go to the hospital to give birth. This implies that the hospital now provides the space and knowledge practices surrounding childbirth that were once more readily available within one's family and/or neighbourhood.

The Importance of Birth Rituals

Birth rituals have been an important practice for rural isiXhosa-speaking families (Mndende, 2006) and are practised in some of the homes in the Mzingisi community. While inquiring informally about special rituals practised after a baby is born, I was told by Zenzi, mentioned above, that new mothers would take the baby's umbilical cord after it had dropped off and then wrap it in something and put it in a scraped out area above the front door, a place cut out of the mud wall and then covered up again. This was to ensure that when a child grows up and leaves home for the mines or somewhere else, they would always return home. When I asked some other women about this practice, they all knew what I was speaking about, and had either followed this practice themselves or had seen their mothers do it after siblings had been born.

When a baby is born, an important public ritual often takes place, called *ukuqaba*, which announces to the community that the baby has come into the world and is being incorporated within the collective world of the living and the dead (Mndende, 2006: 15).

Nomvula explains:

Emva koko, kuxhelwe ibhokhwe kuthiwe kuqatywa umntwana. Le mini kuxhelwayo kuzoza abantu basekhaya mntu othile oyintlabi yalaha ekhaya ozoxhela le bhokhwe. Kuthethwe ke amazwi uba baqaba loo mntana. Kuqatywe ke. Loo mntana ke uqatywa umdiki, imbola le ibomvu. Aqatywe umzimba wonke. Wena ungunina uqabe ubuso. Usogqitywa ukuthethwa ngamadoda phaya esibayeni, ixhelwe le bhokhwe phaya esibayeni. Ihlatywe phaya esibayeni. Ukuba loo mntu akayomfanelo yokuba ayihlabe le bhokhwe ayizukhala, akazuphila loo mntana ngoba lo mntu uyihlabileyo akayomfanele. Xa eyihlabileyo, ihlatywe ngomkhonto apha kule ndawo, ikhale ibhokhwe kuthiwe, "Camagu! Siyabulela" Kutsho oomama. Kutyiwe apha umntana.

Then there's also another ceremony called ukuqaba where they are going to paint the whole body of the baby with the red soil. Then the mother is going to paint and then they are going to take the goat. That goat is not going to be slaughtered by any person. There's a special person within the family, the son of the family, the father of the family who's going to slaughter that goat. When the right person slaughters the goat, the goat has to cry. When the goat is

crying it shows that the ceremony is done well. If the goat is not crying it shows that there is something right and the mothers are ululating "Camagu! We are grateful".

Another ceremony is *imbeleko*, which involves slaughtering a sheep and later using the sheep's skin in which to wrap the child for protection.

Into elisiko, loo mntana kuye kuxhelwe igusha kuthiwe wenzelwa imbeleko. Le mbeleko ke ukuba uyathanda uzathatha esisikhumba umana usoneka kakuhle sisukwe sikhuhlwa ngelitye side sithambe. Xa umbeleka eza ndawo imikhona nalapha emazantsi, uqhina ngayo. Kuthiwa libhayi ke elo. Kuthiwa yimbekelo.

For this child they slaughtered a sheep and they said that they are making him/her imbeleko. With imbeleko, if you like you will take the skin of the sheep and spread it in the sun and scratch it until it softens. When you put the child on your back, you use the skin. So it's called ibhayi [a baby's carrying blanket.] It's called imbeleko.

When I asked Nomvula if she had followed this practice for all her children, she said that she had; however, her daughter, who has a one-year-old baby, had not followed this practice for her son. When I asked Zenzi if her daughter had carried out this practice for her child, she explained that her daughter would need to take her child to the father's family for the ceremony to be performed as it is important for the ceremony to be within the baby's clan. Clan lines are patrilineal, which means that a child assumes the clan name of his or her father (Jansen, 1973).

Another practice that helps prevent problems when a baby begins teething is to collect the seeds of a special vine called *amatetyisa*, which are strung into a "belt" and wrapped around the baby's waist to prevent it from becoming sick. These practices are not necessarily performed exclusively for babies born at home, but are also practised for babies who have been born in the hospital. This became evident when I accompanied a Mentor Mothers outreach worker on some home visits. In one home, I noticed that both of the twins being weighed were wearing white beads around their necks, ankles and wrists. When I asked about this, I was told that they were for protection. These beads were not made with *amatetyisa*, as mentioned above, but were made from small glass/plastic beads similar to those I had often

seen being worn by adults or by traditional healers. This also suggests that there were a variety of beads that can be used for the protection of young children.

Hospital Births

Most women in the community give birth to their children at Mzingisi hospital, which accounts for the 54% increase in deliveries between 2005 and 2008 (NGO website). The number of deliveries has been steadily increasing, with 727 in 2005/6 and 1,778 in 2011/12 (NGO website). The care provided by the hospital is particularly crucial for babies born at risk such as those who are born prematurely, as well as for mothers who face complications during delivery. From my observations and informal conversations with some of the doctors, incubators for premature babies, surgical procedures such as caesarean sections, and access to the Med-Evac helicopter to more specialized services at other hospitals in the province, are important life-saving services accessible to women. Postnatal support, such as education about breastfeeding, immunizations, nutrition, how to administer certain medicines such as ARVs, and general care of the newborn child, is provided by knowledgeable medical staff or outreach health workers.

The hospital and medical staff provide critical support for mothers who are HIV-positive, not only because of the education given about HIV and preventing mother-to-child transmission of the virus at birth, but also because they have access to ARVs. Because of increased efforts by hospital staff and the knowledge, quality of care and dedication of the medical staff, the perinatal mortality rate is considerably lower at Mzingisi than most rural hospitals in the region (Gaunt, 2010). This is reflected in the following statistics for deliveries and the Corrected Perinatal Mortality rate (PNMM) at Mzingisi hospital, which show it has dropped over the past seven years (See Table 2):

Maternity Statistics beginning April to end of March each year for Mzingisi Hospital

	Total	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Maternity	Deliveries	727	1004	1001	1166	1183	1344	1778
	PNMM		44.2	35.4	28.5	27.4	27.7	21.5

Table 2: *PNMM= Corrected Perinatal Mortality, and is the number of babies >1000g who are stillborn or die in the first week of life per 1000 births (Gaunt, 2010).*

The perinatal mortality rate at Mzingisi hospital is under 30 per 1,000 births, which is less than the national average for rural hospitals, which is 42 per 1,000 births (NGO website). Causes of perinatal deaths are varied, but often are associated with mothers not being able to get to the hospital in a timely manner when difficulties occur during labour, and having had limited and insufficient antenatal care (Gaunt, 2010). The table below shows the order of causes over the period of July 2005 to December 2006 and from January 2007 to December 2008. While there has been a decrease in deaths caused by hypertension, ante-partum haemorrhage (APH) and infection, intra-partum asphyxia is the dominant cause of death (Gaunt, 2010: 102).

Table 3 below shows these decreases:

Causes of Perinatal Death	July 2005-Dec 2006	Jan 2007- Dec 2008
Intrapartum asphyxia	21 (32.8)	32 (40)
Unexplained IUD	10 (15.6)	12 (15)
Spontaneous preterm	8 (12.5)	10 (12.5)
Labour APH	8 (12.5)	6 (7.5)
Hypertension	7 (10.9)	5 (6.25)
Infection	5 (7.8)	4 (5)
Fetal abnormality	0 (0)	4 (5)
No obstetric cause	3(4.7)	3 (3.75)
IUGR	1 (1.6)	2 (2.5)
Trauma	1 (1.6)	1 (1.25)
Other	0 (0)	1 (1.25)
Total	64 (100)	80 (100)

Table 3: *IUD = intra-uterine death; APH = ante-partum hemorrhage; IUGR = intra-uterine growth restriction (Gaunt, 2010)*

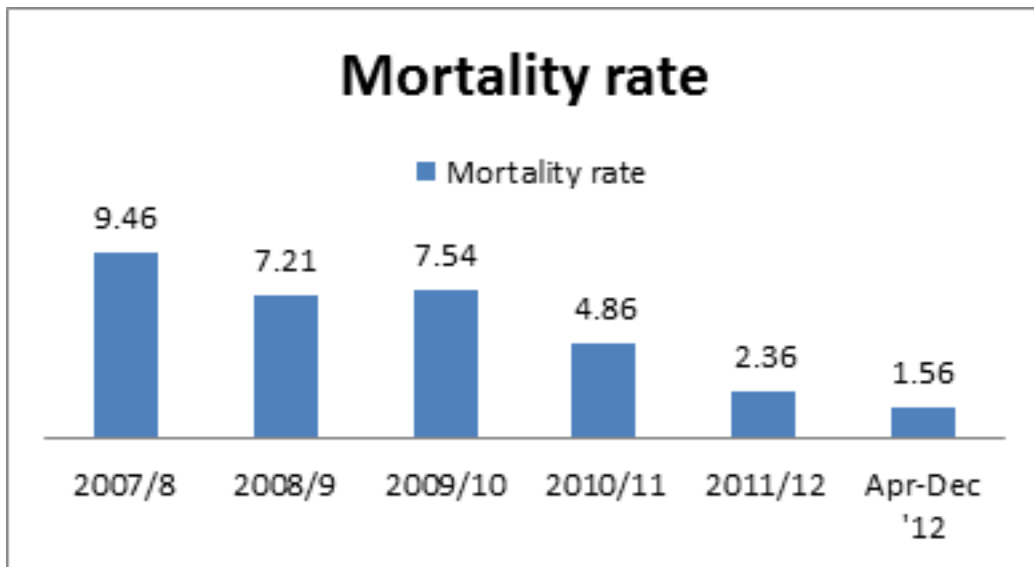


Table 4: Mzingisi Hospital's Overall Mortality Rate (Gaunt, 2013).

The mortality rate at Mzingisi hospital for all admissions has decreased significantly over the past five years (see Table 4 above). This is thought to be due to various improvements in care and other health interventions such as Prevention of Mother to Child Transmission of HIV (PMTCT) or immunizations. While Gaunt (2013) suggests that the decrease probably reflects changes in the community, he emphasized it cannot be extrapolated because of the lack of a proper denominator. The mortality rate for children under the age of one year is usually higher because they comprise the majority of the children that die (Gaunt, 2013). The above descriptions help to paint a picture of the efforts being made to provide quality care, and the positive effect it has on the mortality rates over time.

Antenatal Care

According to one of the doctors, most women who have begun labour remain in the antenatal section of the maternity ward until they deliver. If there are no foreseen complications and they are likely to deliver within 24 hours, they stay in an observation room. Women who live a long distance from the hospital can stay in the “waiting mothers” facility, which comprises three rondavels (round huts) with beds,

a kitchen area and latrines, until they go into full labour. If expectant mothers have complications, they stay in the acute care antenatal ward until delivery. Following are excerpts from my observations recorded in my field notes when I visited some of the antenatal rooms, while on the ward round with Dr. Gwen:

The first ward was an observation room. Here, the first patient has low abdominal pain, which is intermittent. The doctor checks her internally and says that she is 1 cm dilated. She thinks the mom will deliver by nightfall. This is not the patient's first child and her past deliveries have been fine. The doctor says the mother should stay where she is and should take two doses of HIV medicine – Nevirapine – to help prevent HIV transmission to baby.

While visiting the other antenatal wards I encountered patients who had major complications:

The first patient is full term and has high blood pressure. Dr. Gwen explains that if the blood pressure is not above 110/160, then blood pressure medications are not given to the patient until after the birth. This is because the medication can put the baby at risk, and the baby is not in any danger at present. The mother has some oedema (swelling of the hands, feet and legs) but no pre-eclampsia (high blood pressure and protein in the urine after the 20th week of pregnancy). The doctor will wait for her to go into labour, but will induce if it does not happen in the next few days, or if other symptoms appear.

The second patient is having some leakage (amniotic fluid seeping from the protective sac that surrounds the foetus in the uterus). She has not broken her water yet (when the amniotic sac breaks and fluid is released) and has been in labour for 6 hours. If there is no change here, the mom will be moved to the waiting mothers.

The next patient says she is not okay and that she has had on and off contractions for the past 24 hours. She has a headache, but was able to sleep during the night. Doctor Gwen recommends that she drink lots of water, and then tells all the patients to drink water. She then asks the nurse to check that they all have water bottles. This mom has a big belly and very short body. Dr. Gwen will allow her to try and give birth normally, but thinks that she will more than likely need to give her a caesarean. She then checks the mother internally, and the baby. She says that the cervix is long and the baby is low and the head is engaged. This patient complains of pain during the examination – the doctor is manipulating the cervix to try and help the labour along, and she apologizes the whole time while she is doing the examination. If there are more contractions, then the patient will be moved into the labour ward.

The next patient says she is in pain. Dr. Gwen asks her if it is better or worse than the previous day. There is tenderness in the abdominal area, although the mother is only 19 weeks pregnant. She has pain underneath, under her breast area and upper solar

plexus. The doctor examines the stomach and uterus. Apparently there is less tension in the uterine area, and the patient says she is better than yesterday. The ultrasound has shown that the baby is fine. The doctor asks the nurse to order blood work for the morning; she thinks it is early for liver issues, but wants to check anyway.

The last patient is sleeping and had lost her baby yesterday. The baby was too small and the placenta had not been developed enough. Dr. Gwen was very sad and said that they had hoped for the baby to live, but also knew it was probably unlikely. I cannot imagine losing one's baby at birth, and feel very sad for the mother.

These descriptions show the severity surrounding some of the complications regarding pregnancy and childbirth that mothers sometimes have to face, and the kind of care and treatment that is provided for them at the hospital. These descriptions also suggest that if there were no medical facility available, many of the women would undoubtedly face life-threatening circumstances without the possibility of specialized care and treatment. This could mean that they would perhaps have to rely on indigenous practices to treat serious issues concerning pregnancy and childbirth. This would be particularly dangerous for premature babies, who are incubated if they are born weighing less than 2,000 grams. On several occasions I helped a doctor's wife take care of premature babies who were in incubators. She had to go every few hours for feeds and nappy changes, as the mothers were usually too weak or ill to cope.

Postnatal Care

Mothers who need extra care and who may have post-delivery complications can stay and recover, after giving birth, in the post-delivery ward. When I visited the post-delivery ward with Dr. Gwen, I could see that the level of care far exceeded what was available in any woman's home, which could account for why most women in the community are choosing hospital births over home births. The following is a description of the level of care available to maternity patients at the hospital after they have delivered their babies. This information is drawn from my observations and short conversations recorded in my field notes while on the ward round with Dr. Gwen.

The first patient had lost two litres of blood at delivery. She has a catheter to stop her bladder from expanding, thus allowing the uterus to contract. She also has a saline drip. Her baby is clear of HIV and syphilis, and is healthy. The sister comes in and checks her catheter. The patient is breastfeeding her baby.

The next patient's baby is fine. Doctor Gwen examines the baby, which the baby does not like and so is crying. She checks her vital signs – she is sucking well, her reflexes are good and she feeds well. The doctor asks the nurse to emphasize to the mother the importance of exclusive breastfeeding for six months, when it's time for her to be discharged from the hospital. Outreach health workers from Mentor Mothers will come next week to set up routine checks with the new moms and to do follow-ups in the homes. If all goes well, this mom will see the doctor again in six weeks for immunizations and a check up. All the babies leave the hospital with their first BCG and polio vaccinations.

The third patient is also fine and her baby is doing well. Doctor Gwen checks his testes, heart, neuro-reflexes and for jaundice (there's a neat little monitoring device that reads the baby's face). This baby was a vacuum birth and the doctor is particularly concerned about the baby's EKG (electrocardiogram). The next check will be in six weeks. The baby is HIV-positive, so needs to be checked and referred to Mentor Mothers. The mom will get her CD4 count checked at the HIV/ARV clinic.

The next patient delivered yesterday in the "waiting mothers" rondavel. Dr. Gwen notes it as a BBA (Born Before Arrival). A senior assistant helped the mother. This is the mother's fourth baby and she tells the doctor she doesn't want any more children; she has two boys and two girls and wants to be sterilized. The doctor tells her that she can do the sterilization the following afternoon and that she must not eat anything after she has had breakfast. The patient also has to sign a consent form for the sterilization procedure. The doctor then examines the baby. He is fine and a big healthy baby.

The last patient is waiting for a RPR (syphilis test) result, which she must get before she can leave the hospital.

In the next post-delivery ward, the patients need more critical care because they have had complications or delivered early. Two of the patients delivered prematurely, so the care provided to them is crucial for the health and well-being of their babies.

The first patient's baby was a premature baby who weighed 1.4 kg at birth. The patient had a C-section due to a rupture. The mother and baby have been in the hospital for twenty-six days. The baby is now 2 kg. Doctor Gwen is so happy for the mother and child, she claps her hands and dances. She tells the mom she is so happy and that the baby can go home in two days if the 2 kg weight remains stable.

The next patient also had a preemie, weighing 1.940 kg. The baby is jaundiced and had been in the ICU, but did not need a blood transfusion. The baby was incubated with a lamp. The mother had to express milk for feedings while he was in the incubator. The baby is now doing well and when he reaches 2 kg, which should be within the next day or so, he can go home after two days of stability.

The third patient's baby was born this morning in a taxi and is noted as BBA. Her mother was there to help her with the delivery. Dr. Gwen asks about HIV – the patient is negative and the RPR (screening test for syphilis) is negative.

Accessing Quality Care at Mzingisi hospital

Above are highlights of the quality of care provided to mothers in the antenatal and postnatal wards at Mzingisi hospital, and are drawn from observations in the maternity ward and from short discussions with the presiding doctor. In the antenatal ward the quality of care for pregnant mothers waiting to give birth at the hospital is evident, and these findings illuminate the various resources available to women in labour, who either have normal deliveries or who have antenatal complications and need specialized care prior to or during delivery. In addition, according to my observations, it is evident that the doctor is providing compassionate care and support for each patient, and is sincere in her communications with them. As was illustrated in hospital statistics shown above, and according to the doctors, access to this level of care has had a positive impact on the infant mortality rate, which has been reduced over the past several years. My findings also illustrate how the doctors and nurses respond to multiple levels of perinatal and postnatal issues in the maternity ward and utilize various technologies to stabilize mothers and/or babies, such as catheters, saline drips, and incubators for premature babies. Both babies and mothers are monitored regularly and the level of care is adjusted according to the needs of the individual patient. These findings are consistent with data recorded at Mzingisi hospital regarding the decrease in the infant mortality rate and PNMM (Table 2) (Gaunt, 2010). Furthermore, it becomes evident that mothers and babies often require skilled care from medical professionals, which would not be available if the births had taken place at home. Although there are women who have the skills and knowledge to

help a woman in labour give birth and care for a newborn, they do not have skills for emergency situations or for the kinds of symptoms that require biomedical interventions.

Changing Perceptions of Care

The descriptions above suggest that in the past many women may have given birth to their babies at home, but more recently, the presence and reputation of Mzingisi hospital seems to have influenced most of the pregnant women into choosing to have their babies at the hospital (Gaunt, 2010). This also correlates with data gathered in a recent survey of 58 women in the Mzingisi area, by Lipkova and Jeon (2012), who found that the majority of those interviewed had given birth to their children at Mzingisi hospital because they felt that women were better off having their babies there and would be better cared for. According to Lipkova and Jeon (2012), women are advocating to one another that it is better to have their babies at the hospital, which suggests that they believe that their babies' and their own needs will be better provided for in the hospital, rather than at home. While staying in the hospital, the women are being given specific information about how to care for themselves and their newborn child once they go home. They are receiving information from hospital staff about breastfeeding, how to clean the umbilical cord, how to take care of themselves personally, and how to manage HIV if they are infected.

Seeking External Support in Childbirth

As outreach workers come into contact with pregnant women and mothers of young children, they also provide levels of support that the women probably would not get if they were to remain outside of the biomedical and NGO catchment area. In addition to the factors described above playing a role in the decision-making of women around childbirth practices, there may be other factors that they have considered. For example, women may feel that they are better off in the hospital if they have limited support from family members at home, which could be due to a

variety of factors. One factor could stem from the devastating impact of HIV/AIDS, where family members have died and therefore there are fewer women in the household available to help. Another factor may be that family members who have to work away from the area are not present in the home. Some women may also be raising families alone and have no support from family members other than their own children. And some women informed me that due to gendered customary practices, they are unable to rely on their husbands or male partners to help them, even if they were present. In their roles as fathers, men are very rarely involved with the birth or care of their newborn or young children, and are rarely seen in the vicinity of the maternity or paediatrics ward. There are occasionally exceptions, for example, when one of the young women I interviewed told me that her boyfriend had been present in the delivery room when she had her baby in Mthatha, because the doctor had told the young father that he needed to be there to see how a baby is born.

Saving Lives with Biomedical Interventions

Childbirth Interventions

The descriptions above show that the overall mortality rates at Mzingisi hospital have decreased over the past five years¹⁷ and are thought to be due to there being deliberate improvements in health care and a consistent team of skilled doctors who are able to perform various biomedical interventions (Gaunt, 2013). One of the most prominent interventions is the performance of caesarean sections, which have helped to save the lives of newborn babies and the lives of some of their mothers. In one of my informal discussions with some of the doctors, I had expressed my surprise at what seemed to me a large number of C-sections being done at the hospital. This surprise was mostly due to my own bias about biomedical interventions concerning childbirth and my ignorance regarding obstetric issues and procedures. My eyes were soon opened when I realized that the C-sections at Mzingisi were only performed when it was absolutely necessary and were always

¹⁷ See Table 4 on page 172.

because it was the only procedure that could ensure the best outcome and safety of the mother and child. Having the opportunity to observe and witness a C-section in action changed my views completely and helped me see that the safety and well-being of the mother and child were the top priority of the doctors. According to one of the doctors, approximately 15-20% of the deliveries each month are by caesarean section, which averages out to about one per day. Additionally, incubators are provided for premature babies who weigh less than 2,000 grams at birth, and in extreme cases, mother and child are med-evacuated by helicopter to East London.

It is most likely that women who live too far from the hospital, or do not have adequate transportation or money for transportation, deliver their babies at home and rely on women, particularly elders, who have the knowledge to help them during childbirth and the immediate care for the newborn child.

Caring for the Newborn Child

According to Jansen (1973), historically, in this rural area, infant mortality rates were high for the first year of life and the perinatal period was particularly stressful for mothers. Caring for the newborn child took place while mothers were still in seclusion under the supervision or monitoring of midwives (*ababelekisi*). The midwife checked that both the mother and child were healthy and that things were going well (Mndende, 2006). To protect their newborn child from illness, mothers would visit traditional healers, who would make incisions and rub special protective medicines in the skin of the baby and mother. Jansen (1973) contended that new mothers often used the term “i-plate” (*i-playiti*) to describe all types of illness or distresses that their babies were experiencing, and further documented that mothers were in very close contact with their babies from birth to three years old, rarely separating themselves from them. To ensure closeness at all times and to keep their babies safe, they were carried on their mothers’ backs and breastfed on demand. Children were usually breastfed until they reached the age of two or three years old, and weaning was often considered to be a traumatic experience for the

child (Jansen, 1973). Jansen (1973) found that the toddler mortality rate, after being weaned, was particularly high because of the common occurrence of malnutrition. From my observations, most young babies in the community were with their mothers or grandmothers at all times. Toddlers however, were sometimes left in the care of older siblings or children and even left to play on their own within a short distance from the carer.

Indigenous Nutritional Practices

Some of the elder women I spoke with in the community had cared for their babies using indigenous knowledge practices that had been passed on to them from the elders in their families. As was told to me in interviews, indigenous knowledge practices include ways to care for a newborn, preparing nutritious foods, and ways to protect children from illness or bad luck. For example, when a baby is born at home, newborn care includes the birth attendant placing a matchstick in the umbilical cord, after cutting it with a razor or sharp stick. The afterbirth is ground up and mixed with soil and then thrown into the forest. The baby's umbilical cord is cleaned daily with breast milk until it falls off. Once the child's umbilical cord has fallen off, the child can be taken out into the community.

Customary nutrition includes newborns being fed with breast milk and a special thin porridge called *inembe*. This is made from nearly ripe maize kernels that are roasted and finely ground, or from crushed maize that is boiled, and the thick liquid strained.

During a group interview with Faseka, Nomvula and Zenzi (three middle-aged women mentioned earlier), I was told about various customary ways of caring for newborns. Faseka explains the importance of feeding the newborn with traditional foods and preparing traditional medicines for it:

Kukho ezi zinto kuthiwa zizicakathi namayeza epleyiti. Leyiti kwade kwafakwa negrape water noxa ke ngoku apha esibhedlele zingafunwa kodwa kudala zazisetyenziswa. Kangangoko le nto kuthiwa liyeza lepleyiti kwakufuneka uhi

ungekabeleki ulisebenzise usele ukwenzela umntana ukhathazwe yilaa nto kuthiwa yipleyiti. Ufika umntana emizamizeka ingathi uzakubhubha. Phofu nangoku isasebenza nangona kukho le nto yesisibhedlele ingathi iyayigxeka ngoku le nto.

There are things called isicakathi¹⁸ and medicines called ipleyiti. Later there they introduced gripe water even though these medicines are not encouraged in the hospital, but they were used in the olden days. As a result, ipleyiti had to be used before you give birth and drink it so that the baby doesn't have any medical problems like being bloated as if he's going to die. That is still working even though the hospitals are against it.

Isizathu kukuba kufuneka wehlise apha emabeleni umntana angalambi. Kukho ezi zinto kuthiwa zizicakathi namayeza epleyiti. Leyiti kwade kwafakwa negrape water noxa ke ngoku apha esibhedlele zingafunwa kodwa kudala zazisetyenziswa. Kangangoko le nto kuthiwa liyeza lepleyiti kwakufuneka uthi ungekabeleki ulisebenzise usele ukwenzela umntana ukhathazwe yilaa nto kuthiwa yipleyiti. Ufika umntana emizamizeka ingathi uzakubhubha. Phofu nangoku isasebenza nangona kukho le nto yesisibhedlele ingathi iyayigxeka ngoku le nto.

After that they prepare traditional ipleyiti medicines they believe are going to help the child. They are taken from the forest to help the child for ipleyiti and for all sorts of things, and the yellow thing, jaundice. So they prepare all those special porridges for the child. There are some special porridges called inembe, which is taken from the forest.

Nomvula adds:

Ngoomama nabo beve koomama babo. Ibikukutya ngela xesha, isicakathi ibikukutya komntwana. Umntana ebekhula mhlambi enenyanga ede zibeyisix etya esasicakathi.

It's the mothers and they also heard or learnt from their mothers. It [Isicakathi] was baby food during that time. A child would probably be fed isicakathi for three up to six months.

*Sisicakathi nebele.
Isicakathi and breast milk.*

She continues:

¹⁸ Isicakathi is a medicinal plant used as a cleansing for expectant mothers; it is also used for opening the bowel of a newly-born infant.

Upheke iinkobe. Upheke umbona pha eziko, ubile. Usakuqhiba, ziselikhuni, uthathe eza nkobe uzisile, ukrwecisisise, uphinde ufake emanzini, uphinde ubeke eziki, uphinde ukkrwece. Uthathe ke ngoku isefu, isidudu sakho sibe sihle. Ubunobisi ke ngoku sibe mnandi. Kungenjalo ugube umbona, ufake emnanzini, ugube uphinde uwukrwece, uphinde uwukhuphe, uphinde uwuhluze ngesefu. Kungenjalo, ezi zinto ziyithree, ugcade umbona wale xa ezama ukuba brown, uwukhuphe. Wenze kwa esasidudu. Yinembe ke leyo.

Then you cook the grains of maize and boil maize on the fire place. When you are done, while they are still firm, you take the grains of maize, grind them and scratch lightly, put them in the water again and then on the fire place, and scratch them lightly again. After that you strain the mixture and then have a delicious soft porridge. It becomes more delicious with milk. You can also grind maize, put it in the water, grind again and scratch it lightly and strain the mixture with a strainer. You can also roast maize and remove it before it gets brown. You follow the same procedure of doing soft porridge. We call that inembe.

According to Faseka, knowledge about indigenous nutritious foods for newborn children has been reproduced informally from one generation to another, from mother to daughter. However, this knowledge is not always readily accepted and utilized by young mothers in the community. This was illustrated by the response given by Nomvula when I asked if her daughter would use similar foods:

Kuba ngoku, akusekho mbona kuba akusalinywa kuba kwakufumaneka umbona ofumaneka emasimini. Ngoku azisekho eza zinto.

In these days because people are no longer ploughing, so you can't get maize from the field.

Umbona ukhona xa uyowuthenga evenkileni and uyakwazi ukuzenza eza zinto. Bathi abantwana esibazeleyo, "yingcinezelo." Yayilixesha lethu elo. Umqa, umfino bathi yingcinezelo. Thanda ungathandi uthenga ubisi evenkileni.

You can get maize from the shop and you can still do those things. The kids we have given birth to say, "It's oppression." They claim that it was our time. Hard porridge and umfino [a mixture of mielie meal and spinach], they call it oppression. Whether you like it or not, they buy milk from the shops.

This explanation gives the impression that the younger generations are not as attuned to the "old ways" as their parents and grandparents. This is perhaps due in

part to their perception that the use of “traditional” foods locates them in the “past”, so instead, they choose to use more contemporary methods for feeding their children and babies, which locates them in the modernized and “normal” world of childrearing. From my observations and discussions with NGO workers, the ongoing outreach education through the various NGO programmes and nurses at the hospital advocating exclusive breastfeeding, and discouraging the use of “Xhosa medicine”, could also be influencing young mothers’ decisions around feeding. Furthermore, it could be that some of the indigenous “traditional” foods and medicines have been collapsed into the category of “Xhosa medicine”, with the result that young mothers are shying away from preparing and using them in the same way that their mothers did. For example, Jansen describes “*isicakadi*” (*isicakathi*) as a medicinal plant that was used to open a newborn baby’s bowels (Jansen, 1973: 87).

Breastfeeding Practices

According to some of the doctors and outreach workers, all mothers are encouraged to breastfeed their babies exclusively for six months after giving birth at the hospital, but not all choose to do so and some, especially younger mothers, may choose to formula feed instead. Doctors and nurses at Mzingisi hospital especially encourage mothers to breastfeed their babies exclusively for six months. This policy is to help minimize the transfer of the HIV virus from an infected mother to her child, and to prevent babies drinking formula made with contaminated water or from unsterilized bottles, which often results in acute diarrhoea and/or death. HIV-infected mothers are encouraged to exclusively breastfeed their babies and are given the additional protection of an antiretroviral drug called Nevirapine (NVP), which is administered to the baby daily. All pregnant women who deliver their babies at the hospital are tested for HIV, and those who are HIV-positive and are taking ARVs are also given one dose of Nevirapine during labour to prevent mother to child transmission (Gaunt, 2010). The clinics in the surrounding areas have been asked to test pregnant mothers visiting the clinics. If they are HIV-positive, they are

treated with AZT from 28 weeks and then a single dose of NVP during labour (Gaunt, 2010: 102).

Issues Surrounding Breastfeeding

An NGO based in the community, has a team of outreach workers called Mentor Mothers who specifically provide outreach to new mothers through in-home visits. Their goal is to prevent mother-to-child transmission of HIV and to support new mothers with breastfeeding, child nutrition, and monitoring the growth and health of their children who are under six years of age. From my observations and informal conversations, the Mentor Mothers' message is the same as medical workers at the hospital, which is to breastfeed exclusively for six months. Additionally, two Mentor Mothers visit the maternity ward twice a week to advocate exclusive breastfeeding and to check whether any new mothers have been referred to them. Generally, mothers who choose not to breastfeed are either HIV-positive and feel that breastfeeding will increase the risk of infecting their child, or are young mothers who would rather not breastfeed and instead think that it is fashionable to formula feed, because it shows others in the community that they are "not poor". The young mothers I interviewed indicated that their boyfriends bought them formula each month and so they felt that they should give it to their babies. Some women mix breastfeeding with formula feeding because they have family members taking care of their babies during the day, while they are at work or attending school. Mixing breastfeeding with other foods was also an indigenous feeding practice, as was explained by Nomvula earlier. Research has also shown that across South Africa, many women believe that exclusive breastfeeding will not provide sufficient nutrition for their babies and so incorporate mixed feeding (MacDonald, 2011). HIV-infected mothers, however, are more likely to pass the virus on to their babies if they mix feed. Some infected mothers also believe that by using exclusive feeding methods, it will indicate to their families that they are HIV-positive, and they will consequently have to suffer the stigma attached to being infected (Macdonald, 2011).

In the next section, I describe some of the issues surrounding teenage pregnancy and how it relates to the structure of the family and the community as a whole.

Teenage Pregnancy

While conducting my fieldwork in Mzingisi, I noticed that teenage pregnancy was quite common and seemingly accepted by most people. However, after having conversations with older women, it became apparent that while teenage pregnancy was accepted, it was not condoned, especially by elders. Historically, young women were often married during their teenage years and therefore gave birth to their first child at an early age. One elder told me, in an informal conversation, that when she was growing up, if an unmarried teenage girl became pregnant before marriage, then her family would have to be compensated by her boyfriend's family, and all the girls in the neighbourhood would be punished. She explains below:

Intombi ukuba kuthe kwamitha, masenze umzekelo, uba yintombi yalapha, iintombi zonke zikhululwa zonke, kukhululwe necici. Kwanto! Zingaxibi. Kubonwe kulolali ikhona intombi emithiyo. Zingaxibi njengokuba besinxiba izinto. Kukhululwe njengomntu ozilile. Nento esenyaweni unganxibi nto ngoba nizilile. Nizilele la ntombi kuba nithi, ukuba umntu udibana nawe uvele aqonde yho iintombi zasekuthini, uzakubuza ukuba ngubani loo umithiyo ngoba uyabona uzilele intombi emithiyo.

If a girl falls pregnant, all the girls of the village have to take off their clothes and earrings. Everything! They should not wear anything. Then that village would know that there's a pregnant girl. They shouldn't wear anything to show that they are in mourning. They are mourning for this girl. A passer-by would immediately know and would ask who the pregnant girl is because he can see that you are mourning for this pregnant girl.

In an interview Faseka (mentioned above) tells me:

Umntana oyintombazana kudala wayefostela endele kuloo mntu angamfuniyo. Ukuba umntwana oyintombazana uthe wapregnant kuzothiwa makendele nobi'into inelihlo elinye, inyhola, noba inesifombo nobinjani nobilixhego ukuba uthe wabapregnant. Akuthandiswa wena. Kwel'ixesha likhoyo akuthandiswa wena. Wonk'mntu uyazikhethela. Uzavela abizamapolisa kweli xesha ngoku, akubambise ukanti kudala.

In the olden days a girl child was forced to marry someone she doesn't like. If a girl happens to fall pregnant, she would be forced to marry even to a one-eyed thing [man] or to someone who has a hump on the back, even if it's a man old enough to be her grandfather. It's not up to you. In these days, everyone chooses her own [husband] or else she will call the police and get you arrested.

This may account for why today elders seem disappointed or shocked by the rate of teenage pregnancies or when a teenager in their own family becomes pregnant. Nowadays, many of the young mothers become pregnant and have their babies before they turn 18 years of age. In goal number five (improve maternal health) of the Department of Health's Millennium Development Goals, the following statistics show the percentage of deliveries to young mothers under the age of 18 in health facilities in the Eastern and Western Cape. The percentage rates for the Eastern Cape are considerably higher, at 10% in 2009, than those for the Western Cape.

**Percentage of Deliveries for Women under 18 years in Health Facilities
2001-2009**

Province	2001	2002	2003	2004	2005	2006	2007	2008	2009
Eastern Cape	12,4	11,2	9,9	9,2	9,9	10,2	10,8	11,0	10,0
Western Cape	7,5	7,9	8,0	8,2	8,4	8,7	8,3	8,2	7,3

Table 5: Source: District Health System, Department of Health.

Several of the doctors at Mzingisi hospital stressed that many of the young mothers are ill-prepared for motherhood and often do not know they are pregnant until their bellies start growing bigger. At this time, they usually seek antenatal care at a clinic located closest to them. Many of the young mothers arrive at the hospital in labour, sometimes accompanied by an elder. Some of the women are as young as 14 or 15, and have very little knowledge about labour and childbirth. Many of the young teenagers end up having a caesarean because their bodies are too underdeveloped to give birth naturally.

Three Young Women's Stories

I conducted semi-structured interviews with three young women who had become pregnant while still attending school, to see what they knew about pregnancy and childbirth before they had become pregnant.

One young woman, Lungi, said in an interview session that she did not know much before she got pregnant and had only learned a bit from her mother about breastfeeding for the first six months and giving solid food after six months. At school, in Life Sciences class, she had learned about stages of pregnancy, changes in the body, and that they should use condoms to prevent HIV and go to the clinic for injections to prevent pregnancy. However, she later admitted that she had learned a little bit about caring for children through her own experiences at home because she used to take care of her younger siblings.

Another young woman, Pumla, aged 17, said she also knew very little about pregnancy or childbirth before she got pregnant and that her mother had not told her anything. She knew that when someone is pregnant they have likes and dislikes regarding food: not liking samp and beans, or meat. In discussions with her friends about pregnancy or childbirth, the emphasis was on how one's looks change after having a baby rather than about the process of pregnancy and childbirth. As with Lungi, she too had some experience taking care of her younger siblings and doing tasks like washing them. At school, in her Life Orientation classes, she was told that she should not have sex at a young age because of the risk of sexually transmitted diseases, but also that she should use condoms if she does have sex, and get birth control injections from the clinic.

Thandiwe, a young mother who is 20 years old, became pregnant at the age of 19 while in the 10th grade. She told me in a semi-structured interview that she did not realize she was pregnant until her sister pointed it out when she started reacting to the smell of certain foods that made her feel nauseous or vomit. When I asked her

what she knew about pregnancy and childbirth prior to her getting pregnant, she said she knew nothing and had not had any guidance in school. Her mother had told her not to get pregnant at a young age, but had not given her any information about birth control.

Barriers to Using Contraceptives and Unprotected Sex

School-going teenagers and young women often know that birth control is available at the clinics, but do not often utilize those services. Accessing the contraceptives also presents challenges to the women. When I asked two of the young mothers I interviewed if they had thought about using contraception before having sex, one said that she knew about getting injections at the clinic, but did not go because she was afraid her mother would ask her where she was going when she passed by her place of work. The other said that while she had been using contraception, she could not continue because by the time she was finished at school each day, the clinic was closed. In addition, young women who are still in school usually do not have extra money to pay for transportation to and from the clinics, nor do they want their parents to find out that they are sexually active. This results in them not going to the clinics to access contraceptives, and then becoming pregnant. In many cases, teenagers as young as 14 and 15 years old are having babies, often without support from the baby's father.

According to information I gathered in informal discussions with health workers, most teenage and young women practise unprotected sex for reasons other than those mentioned above, usually because their boyfriends do not want to use condoms. The men also do not want to get tested for HIV or know their status. The three young women I interviewed did not know the status of their boyfriends, but had been tested themselves when they went to the clinic for antenatal care. These young women had not used contraceptives as a preventative method against pregnancy, or condoms as a protective method against HIV. This phenomenon is similar to recent data gathered in the Mzingisi area, where the majority of the young

women interviewed who were pregnant, or had given birth at an early age, knew that condoms and birth control injections were available at the clinic, but had not actually gone to the clinics to get them (Lipkova & Jeon, 2012).

Complexities Surrounding Teenage Pregnancy

It becomes clear from the data presented that the issues surrounding teenage pregnancy and birth control are multiple and complex. What appears to be evident is that teenagers live within a community of practice that has some knowledge about pregnancy and childbirth, and yet has difficulty implementing aspects of that knowledge into their personal lives. For example, many young men and women know that birth control is available as a means of preventing pregnancies and HIV infection, yet few are able to obtain and use the contraceptives. One reason for this is a fear of parents finding out that they are sexually active. Another reason is because extra money for transportation to a clinic is beyond their means.

Power structures within sexual relationships are a factor, particularly with regard to women and their use of birth control, which this research has shown is a gendered issue. The three young women I interviewed revealed that they were responsible for their fertility, and yet were fairly powerless to maintain this control. Although the young women knew that condoms could protect them against HIV/AIDS infection and pregnancy, none of their boyfriends were using them. When I asked Pumla if young men had access to condoms, she said that they had to get them at the clinic, although at times a peer educator would bring them to the school when giving a presentation.

It became apparent during the interviews that the issues surrounding contraception and HIV prevention were complex, both for the young women and their boyfriends, and due to the gendered power dynamics within their relationships, the women did not seem to have the power to ensure that they were practising “safe sex”. Furthermore, because the man is going to be the one to use a condom, it could be

perceived as “men’s business”, which would prevent the women from being able to broach the subject. While many young men in the community know about the protective factors of condom use, these young men chose not to use them. They also did not take any responsibility towards preventing their girlfriend’s pregnancies or protecting them against HIV infection. This points to the men having fairly careless attitudes towards their sexual relationships and towards their own health and well-being, which is a reflection of the general narrative of how men operate regarding sex and HIV in the community. According to the women I had spoken with, including some doctors and health workers, most men, including those working at the hospital, are reluctant to use condoms or get tested for HIV. One doctor disclosed to me that she had begged a hospital employee to get tested and know his status and that he was very reluctant to do so, although eventually he did.

Sexual relationships between men and women seem to be highly gendered in that the men have the most control in the relationship and do not expect women to have a say about sexual matters. Women who want to control their fertility tend to use birth control injections, or get sterilized at the hospital after they have had several children. Because men are reluctant to use condoms and are often the ones who become infected with HIV, women have little control over whether they contract the HIV virus or not and have to remain subservient to the patriarchal system and their partners’ demands.

The gender inequalities and issues surrounding pregnancy and HIV infection in teenagers that surfaced in this research are consistent with research conducted in other rural areas across the nation (Harrison, Nonhlanhla & Kunene, 2001). It is also consistent with research by Jewkes, Morrell and Christofides, who argue that a young woman’s “subordinate position in the gender and social hierarchy” diminishes her agency around sexual relationships and pregnancy (Jewkes, Morrell & Christofides., 2009: 675). Jewkes, Morrell and Christofides (2009) also argue that men are eager to become fathers to prove their masculinity and often pressure young women into becoming pregnant as a proof of their love.

Gender Inequalities in Sexual Relationships in Relation to HIV

Using contraception to prevent getting pregnant and contracting HIV is often a responsibility left in the hands of women. According to some of the women and doctors I spoke with informally, many of the women who do use contraceptives prefer to get an injection every three months rather than getting condoms, because they can keep it a secret from their partners, who are not very keen on using contraception. This means that the women only need to visit the clinic a few times each year. This, however, does not protect them against contracting HIV, an imposed risk, caused by the fact that the women do not have the power to protect themselves because they are trapped within the structure of inequality inherent in the relationship. Women therefore usually cannot rely on their husbands or partners being willing to use condoms as a form of birth control or as a preventative measure against HIV. As with teenage women, research has shown that older married women often cannot broach the subject of condom use with their male partners because they do not have the power to control their own sexuality (Harrison, Nonhlanhla & Kunene, 2001). As mentioned earlier, mothers who deliver their babies at the hospital and have several children are offered sterilization to enable them to stop having more children than they want.

While efforts are continually being made by outreach workers and the HIV clinic counsellors for men in the Mzingisi community to test for HIV, they claimed that many men are still reluctant to be tested or use condoms. In order to encourage young men to get tested for HIV, two NGOs in the community sponsor HIV-testing drives annually. One of the events I witnessed was a football tournament between several local teams and a team from Cape Town, with musical and theatrical entertainment that encouraged people to test for HIV. The tournament was located at the local junior secondary school, so the testing and counselling could be done in classrooms near the sports field. As a further incentive to get the young men to test, prizes such as T-shirts were given to each young man who got tested.

Reluctance to get tested is thought to stem from the stigma still attached to HIV-infected people, although I was told by NGO workers that stigma is less of an issue than it was several years ago. The reluctance to get tested is consistent with trends documented in Jonny Steinberg's book, *The Three Letter Plague* (2010), where he found in the Port St. Johns and Lusikisiki areas, that young men especially were unwilling to be tested for HIV or use condoms as a preventative against contracting the disease; this had a lot to do with stigma attached to those infected with the virus, as well as with the fear of actually knowing one is infected.

According to some of the doctors, men who are migrant workers and come back to the Mzingisi community a few times each year are often involved in multiple sexual relationships, in addition to the one they have with their wives. These men are generally known in the community to be reluctant to use condoms or to get tested for HIV when they return. Some doctors at the hospital disclosed that many of the men returning from migrant labour jobs have contracted HIV while they were away working. According to the doctors, this correlates with the marked increase in births, and the increase in the number of women being HIV-positive, every September, that is, approximately nine months after migrant workers return to Mzingisi. The relationship between the increase in the number of births and the increases in HIV-positive mothers in September exposes some of the devastating effects of patriarchal hierarchies and gender inequalities within family structures.

Table 6, below, gives statistics showing HIV infection rates of women in antenatal care at Mzingisi hospital, over a five-year period from 2007-2012. These statistics show that the percentage of identified HIV-positive women in antenatal care has increased during this period. Although the number of women who are identified as HIV negative is significantly higher than those who are positive, the percentage rate has decreased over the period.

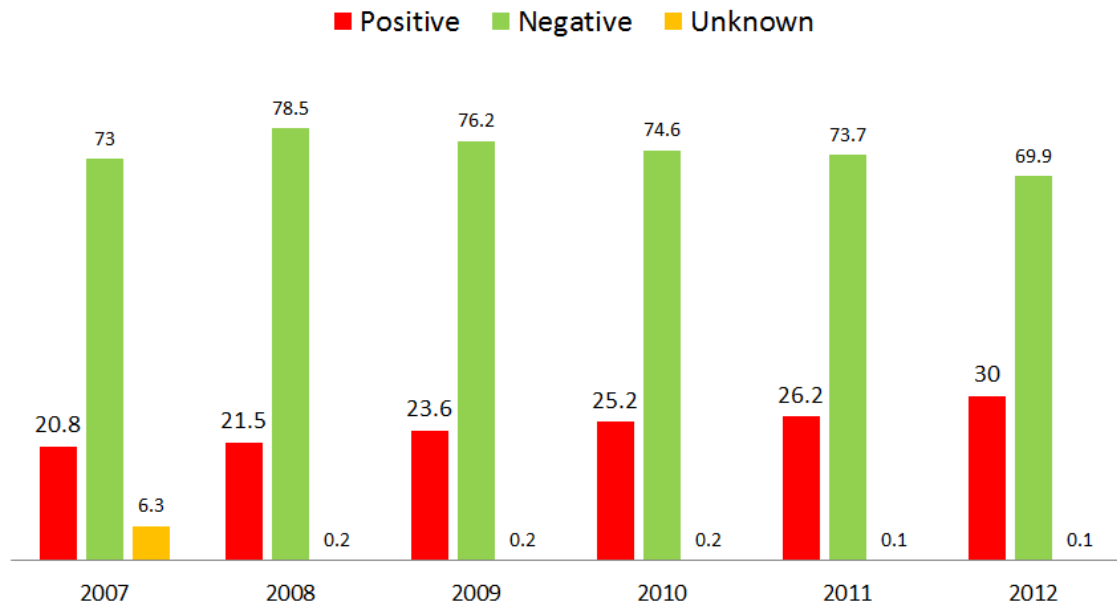


Table 6: Percentages of Women in Antenatal Care Infected with HIV (Gaunt, 2013).

Formal Education and Birth Control

School-going teenagers are exposed to classes in Life Orientation (LO), which is a required subject in the general school curriculum for all Grade 10 to 12 students. Learning Outcome 1 of the Learning Programme Guidelines, 2008, has a focus on Personal Well-being. Within this outcome, an area of learning is to “Explore characteristics of a healthy and balanced lifestyle, factors influencing choices and behaviour in the promotion of health, and the impact of unsafe practices on self and others” (DoE, 2008: 27). While it is the responsibility of teachers to create and teach lessons regarding healthy lifestyles to their students, many schools fall short of implementing a comprehensive Life Orientation Programme (Prinsloo, 2007). The information students receive from LO classes is often delivered via text and abstract examples, which may seem irrelevant to the realities of the everyday lives of the learners. Prinsloo (2007) argued that teachers often were not trained to teach many of the subjects within the LO curriculum and thus felt ill-prepared, so avoided teaching content they were unfamiliar with. And in rural areas in particular, Prinsloo found that teachers also felt that they were disconnected from their students’ realities and did not relate to their students in those classes.

While the issues surrounding teenage pregnancy may appear to be linked to lack of knowledge and gender inequalities, there could also be links to changes in how families and the community are structured. Historically, young women were often married at a young age and their sexual encounters were limited. However, there is speculation that new teachings from the church and Christian values, combined with changes in social structures, gave way to changes in teenage sexual behaviour (Delius & Glaser, 2002).

Filling the Knowledge Gap

The experiences of the young women I interviewed present an issue that seems to be consistent with the experiences of many young women in the community. Lipkova and Jeon (2012) found that most of the young mothers they interviewed in the community did not receive advice from anyone regarding pregnancy, but those who did get advice received it mostly from their mothers. The lack of knowledge regarding what happens during pregnancy and childbirth seems to point to a deficit in clear information being shared by mentors such as mothers, aunties, sisters and elders. This could be because there are changes in the structure of how girls and young women are socialized within the community, which has caused a breakdown in the sharing of knowledge. Rather, reliance is placed on anecdotal information such as the probability of one's food preferences changing, or "legends" such as eating certain foods having negative effects on one's child. Additionally, value is placed on "text-book" information given to them through the Life Orientation curriculum, in more formalized settings such as the classroom, which does not so easily translate into internalized knowledge. This brings to the surface the question of why this knowledge is not being passed on from elders to young adults.

One possible reason may be that along with the ongoing influences of modernity, such as social media, come greater influences from more formal educational institutions such as the hospital and schools. Elders may feel that there is less need

to pass on knowledge to younger women and that young people do not want to “listen” to them, as their knowledge is perceived as “old fashioned” and irrelevant. This suggests that there is a clash between values and knowledge practices. For instance, as recently as the 1960s and 70s, if a young woman got pregnant and was not married, then all the girls in the village were punished to deter any other young women from having similar ideas. Consequently, the young man’s family would have to pay reparations to the girl’s family. Furthermore, older girls or young women often supervised young girls closely so that behavioural expectations were kept. Although sexual intercourse was taboo for unmarried young men and women, the practice of *ukumetsha* allowed them to have intimate relationships without penetration, thus usually preventing pregnancy from occurring. While these methods may have been relevant in the past, they no longer seem to be adequate methods of “controlling” young people’s sexual behaviour today.

The contradictions in knowledge reproduction that this research has surfaced is consistent with Delius and Glaser’s (2002) research in rural and urban settings in the former Transvaal province, which reveals that there was a huge gap in the passing of knowledge from elders to young people about sex and pregnancy. Delius and Glaser (2002) argue that there is a historical archive of incidents that helped to shape this gap, beginning with European conquest, influences from Christianity and cultural shifts stemming from migrant work on the Witwatersrand, and most recently, the impact of AIDS. As more men and women left the rural areas to work, and as Christian values took precedence over traditional values in formalized education, elders had less and less influence on young people’s sexual behaviour. There was also less structural organization within age cohorts and older peers, which allowed more unsupervised time and a greater possibility for breaking sexual boundaries (Delius & Glaser, 2002). According to Mayer and Mayer (1970, cited in Delius & Glaser, 2002), historically, in isiXhosa-speaking communities in the former Transkei, known as the “red” people, elders often held open discussions on sexual matters with young adults and adolescents, and sanctioned sexual play, as long as pregnancy did not occur. While many of these practices seem to be disappearing,

young men's families are still expected to pay reparations if they get a young, unmarried woman pregnant. This was confirmed by two of the young women I interviewed, who mentioned that "reparations" were paid to their families in the form of cash, although they did not know exactly how much.

The gap in knowledge could also be due to the ongoing changes in social structure, which directly influence how young people act and how they respond to the society within which they live. As such, young people influence one another, as they are influenced by the social structure, and while they know what is expected of them by elders and cultural norms, they are not always able to comply. Giddens (1984) contends that human agents navigate their way through their daily interactions tacitly aware of the rules or codes of social practice, and always have a choice about how they act, but do not always have control over their actions. Their day to-day production and reproduction of social practices also draw from the social practices of the macro social systems.

Socialization of the Child

Historically, children were socialized within the safety of their homesteads with their mothers close at hand to tend to their needs. There was relatively little influence from outside the homestead community, and children were raised within the context of the cultural norms and practices of community members and society.

From my observations, children continue to be highly valued and in most families are viewed as a blessing. Mothers and grandmothers are usually the primary caregivers, but grandmothers tend to be the primary caregiver if the mother is still attending school or is at work. Babies are carried on their mother's or grandmother's back, keeping them close to them at all times. They are held in place with one or two blankets, which are tied around the mother or grandmother's waist and chest. In this way the mother or grandmother can complete the many daily tasks necessary to maintain a homestead, and have the child close at the same time.

If a mother is away at work during the day, she will spend time with her children in the evenings and at the weekends. According to a preschool teacher in the community, it is during this time that children play counting games and learn important proverbs and folktales, sitting around in the hut in the evenings with their parents or grandparents. Children learn valuable lessons from their elders at a young age and tasks are often gender specific. These tasks are usually linked to future adult responsibilities and roles related to the ecology of the homestead such as collecting water, washing clothes, cooking, ploughing fields and growing and harvesting crops, hunting, fishing and various tasks required to maintain a hut.

Educating the Young Child

During my fieldwork, I volunteered at the Mzingisi preschool. Here, I was able to gain insight into some of the issues in the area regarding early childhood education and education in general. I had the opportunity to engage with mothers, grandmothers, aunts and other educators in the community as well as government entities concerned with expanding early childhood education in the area. There are several preschools in the Mzingisi area within a 2-4 km radius, most of which are poorly equipped, overcrowded and operating with limited financial support, if any. Even with the support from an NGO, Mzingisi preschool's facilities were very basic. The preschool is comprised of two round huts, one for a classroom and one for the storage area. Both buildings are leased from the church for a monthly fee. Initially, when I first began volunteering, there was no running water or hand-washing facility, and only one latrine in the yard behind the school. To have water readily available each day, the assistant had to fetch water in a bucket from across the street and carry it on her head back to the school for the children to use. Having little access to water resulted in poor hygiene practices being implemented in the daily routines of the children. In addition, the electricity supply was erratic and was unavailable from the end of 2011 and through most of 2012.

During the time of this study, many improvements were made to the facilities. This included a 5,000 litre rainwater tank with a tap, hand-washing basins, child-friendly latrines, and a vegetable garden to supplement the school's feeding programme. The Mzingisi preschool curriculum emphasized health and well-being in all aspects of the children's lives, which was better implemented once the school's facilities had been upgraded. Because of its close proximity to the hospital and ongoing support received from some of the doctors, children had physical check-ups each term and visited the dentist at the hospital each year. Each child had a toothbrush and after the midmorning meal, children brushed their teeth. Healthy eating habits and healthy lifestyles were emphasized daily as well as through specific learning activities.

In informal conversations with some parents and women in the community, I was told that the majority of young children between the ages of three and five spend most of their early years in the care of their mothers, or grandmothers, but may attend a crèche or preschool for a few hours a day during the week. Most parents value formal early childhood education because they believe that their children are then better prepared for school, both socially and academically (Lipkova & Jeon, 2012). However, not all childcare is of equal quality and some crèches are oriented more toward babysitting than education. Coming up with the money for school fees each month for preschool can be difficult for many families, which results in preschools struggling to provide wages for their teachers. Most children attend primary school from the age of six or seven, although there is a tendency to send children at a younger age because school officials in the area are willing to take children from age three or four. This, I was told, is because funding for schools is often based on the number of pupils attending. Attending the local primary school also saves parents having to pay preschool fees, or pay someone to care for their child if no one is available at home. But, this also means that many grade R (kindergarten) classes, in particular, are overcrowded and many young children do not benefit fully from attending school. Teachers in the community often complain

about the large numbers of children in the grade R classrooms they are teaching in, some with as many as 90 children under the age of five.

After attending several meetings with preschool council members and the primary school Principal, an NGO which supports several projects in the community, including the preschool, decided to fund a new preschool to help relieve overcrowding in the grade R class and to provide better ECE facilities and opportunities in the area. The Council members agreed to provide labourers and the sub-headman provided a secure area to store building materials, which is an example of how reciprocity can be realized through everyday decisions and choices, and is in line with the customary practice of Ubuntu.

Gendered Roles of Childrearing

Childrearing and socialization is highly gendered and the greatest responsibility for raising children is placed on women. Children are raised in varying situations and circumstances but almost always with the support of a relative. Men often play a background role with regard to childrearing, mostly because it is considered to be “women’s business” and the customary practice has been for women to take care of the children, especially when they are young. From my observations, this is evident particularly with young, unmarried mothers, who tend to live with their own parent/s or relatives rather than the family of the child’s father. When children are older, women usually spend more time supervising and taking care of their daughters and granddaughters. Their sons may spend time with the men of the family, but are still mostly cared for by their mothers or grandmothers. I have also observed that men actively spend time with their sons when they are busy doing “male” tasks such as hunting, fishing, taking care of livestock, building fences and other menial tasks. Young boys are often observers until they are able to carry a task out by themselves, and are often with an older sibling or relative when assigned to a task such as watching over livestock. Skills-building in this way is aligned with what Lave (1991) terms “Peripheral Participation”, when learning takes place within a

community of practice such as in gender-specific childrearing, and where learning is a continual dimension of one's life, moving from an apprentice role to expert, over time. Learning is done through participating peripherally in activities that support gaining the appropriate skills needed to carry out and eventually master a task.

Although the main responsibility for raising children is placed on women, this is not to say that men do not play any role in their children's lives. From my own observations I saw men accompanying a young child to the store, or holding a baby while walking through the village. While visiting a homestead, I observed a grandfather actively playing with and talking to a young baby while holding it on his lap. I also saw young couples together with their child, and another time when a man helped his partner tie a baby on her back. There were also fathers or uncles who brought or fetched their children to and from preschool, although this was usually when the mother or caregiver was unable to do so. There were also some men in the community who looked out for a young boy whose mother prepared food outside the hospital. The young boy spent many hours playing next to the road or walking up and down interacting with passers-by and other street vendors. On many occasions, I witnessed a guard or taxi drivers playing or spending time with the boy. There were several of us who were affiliated with the hospital or NGOs that also felt a sense of responsibility toward his safety and well-being.

Gender specific roles seem to be accepted by most women, on the surface, and there are seemingly appropriate times and spaces for these roles to have their place. This was particularly evident when women had to see a doctor of the opposite sex at Mzingisi hospital. Women often expressed to female doctors that they were uncomfortable when they had to see a male doctor about "female issues", or when a male doctor attended to them when they gave birth, but they also understood that the male doctor had specialized knowledge to care for them. Having male doctors caring for women exposes a contradiction of gendered roles in the context of customary practices, although it is often the "norm" in "Western" contexts. Lipkova and Jeon (2012) were told by one woman they interviewed, that she preferred to

deliver her children at home because she did not like having a male doctor tending to her. With regard to childrearing, some women disclosed to me in informal conversations that they thought men should be more involved with aspects of childrearing and childcare, indicating that they would no longer readily accept the gendered roles of childrearing without some form of contestation, even if they did not have the power to necessarily change the status quo. This is an illustration of Giddens' "duality of structure" where actors "draw upon and reproduce social structural features from wider social systems" (Giddens, 1984: 24-25). Moreover, they are experiencing and participating in a social structure that is both enabling and constraining.

Seeking External Support in Childrearing

Health care providers and outreach workers play a significant role in supporting mothers and their children in maintaining their health and well-being via education and providing better access to health care. This is often on a one-to-one basis with emphasis placed on nutrition and preventative health measures. Based on my own experience in the community, preschool teachers may also provide support to parents and/or guardians through ongoing dialogues regarding various aspects of their child's development, including health, behaviour and learning. Teachers also act as caregivers and provide security in the lives of young children, particularly because they create caring and interesting environments for the young child to develop in and explore. Teachers also notify parents when there are issues concerning the child's health and advise them to visit the various structures available, usually the clinic or a doctor at the hospital.

While most mothers hope to raise healthy children and families, it can be a struggle for many women, especially if they are living with limited resources or have little support in the way of an extended family or spouse. The lack of resources has led to greater reliance on social and medical services provided by the community's hospital, NGOs and government structures, whose main roles are to support the

well-being of families in the community. Although many families eke out an existence by growing food, they still rely on monthly social welfare grants as a regular source of income, which is approximately ZAR 280 per month, per child (www.services.gov.za). And while many of the mothers are eligible for the grant, it is often a prohibitively daunting and costly process that requires several trips to the nearest town to visit the Department of Social Development, and is a 45 to 60 minute journey by taxi. Increased government bureaucracy has also added challenges to getting social grants because documents such as identity cards and birth certificates are required for all family members, which in the past were not provided in many of the rural areas. Instead, births were recorded with the local Headman of the village, and written documents were not provided. Consequently, many families go without the grants that are due to them, which increases the burden they are already enduring.

Conclusion

In this chapter, the descriptions and discussions have shown how practices surrounding childbirth, childrearing and socialization reflect many of the complexities present in people's lives in this community. In the above descriptions it emerged that there were two systems of knowledge practices, biomedical and indigenous, running alongside each other and that women utilize both systems to support their own and their children's well-being, despite their being tensions between the two systems. I argued that influences from both the hospital and NGOs, combined with quality care and biomedical interventions, have influenced the choices women make regarding childbirth practices, and that NGO outreach workers act as boundary workers and often mediate between the two systems.

It was also evident that women's choices were often constrained by gendered power relations, especially around contraception and HIV prevention, or constrained by poverty and lack of material resources. Furthermore, this chapter surfaced that there was a knowledge gap regarding pregnancy and childbirth, which pointed to

their being differences between historical knowledge practices such as *ukumetsha* and the current knowledge practices of using contraception. These differences are a result of the social practices, within which knowledge was embedded, having changed or disappeared.

The following chapter will give an in-depth analysis of some of the themes that surfaced from the stories that were told in Chapters Four, Five and Six. To do that, I will use Engestöm's CHAT as a heuristic tool to investigate women's agency and the choices they made around well-being.

CHAPTER SEVEN

MAKING SENSE OF THREE STORIES

Introduction

In the three previous chapters, I gave detailed descriptions about how life is lived in the ecology of the homestead and the various health practices and childrearing and socialization practices that have evolved. Within those chapters, some noteworthy stories unfolded involving women's agency and the choices they made around individual and collective well-being.

This chapter seeks to answer the following question: How do we make sense of some of these remarkable stories? In order to answer this, I will do an in-depth analysis of three themes that were revealed in the previous three chapters and attempt to bring meaning to some of the decisions and choices women make regarding:

- Using biomedicine almost exclusively for childbirth.
- Remaining subject to the patriarchal system.
- Performing indigenous rituals and ceremonies to cultivate and sustain their well-being.

Using Engeström's CHAT (Cultural Historical Activity Theory) as a heuristic tool, I will identify and explore the activity systems present within these stories and investigate some of the layers present in those systems that might provide answers to the above question. Before I analyze the three cases, it might be useful to look again at CHAT.

As noted in Chapter Two, post-Vygotskian psychologist, Engeström, developed CHAT as a way of embracing the multiple world-views and interrelations taking shape between multiple activity systems (Engeström, 2001). Activity systems

contain diverse points of view from the collective and the community levels, rather than just at the individual level (Daniels, 2001). Activity systems evolve and change over time and are shaped by their historical archive, which informs reproduction in the present (Engeström, 2001).

The subjects/participants in the activity system carry with them their own histories, and the activity system itself carries multiple layers of history woven into the artefacts, rules and conventions (Engeström, 2001: 136). Activity is mediated through artefacts or tools such as orality and language, and social, cultural and historical contexts, to create meaning, understanding and knowing. Engeström explains the activity systems in five principles, summarized as follows:

1. The collective, artefact-mediated and object-oriented activity system, seen in its network relations to other activity systems, is the prime unit of analysis.
2. An activity system is always a community of multiple points of view, traditions and interests.
3. Activity systems take shape and are transformed over lengthy periods of time. Their problems and potentials can be understood against their own history.
4. Contradictions are historically accumulating structural tensions within and between activity systems.
5. Activity systems move through long cycles of qualitative transformations.

(Engeström, 2001: 136-137)

Considering that activity systems are multi-layered and multi-voiced, the triangle depicting the structure of the activity system can be viewed as three dimensional, like a pyramid or tetrahedron, so that the multiple, socio-historical layers representing the deeper and hidden aspects within a social system such as historical trauma or intergenerational issues can also be illuminated.

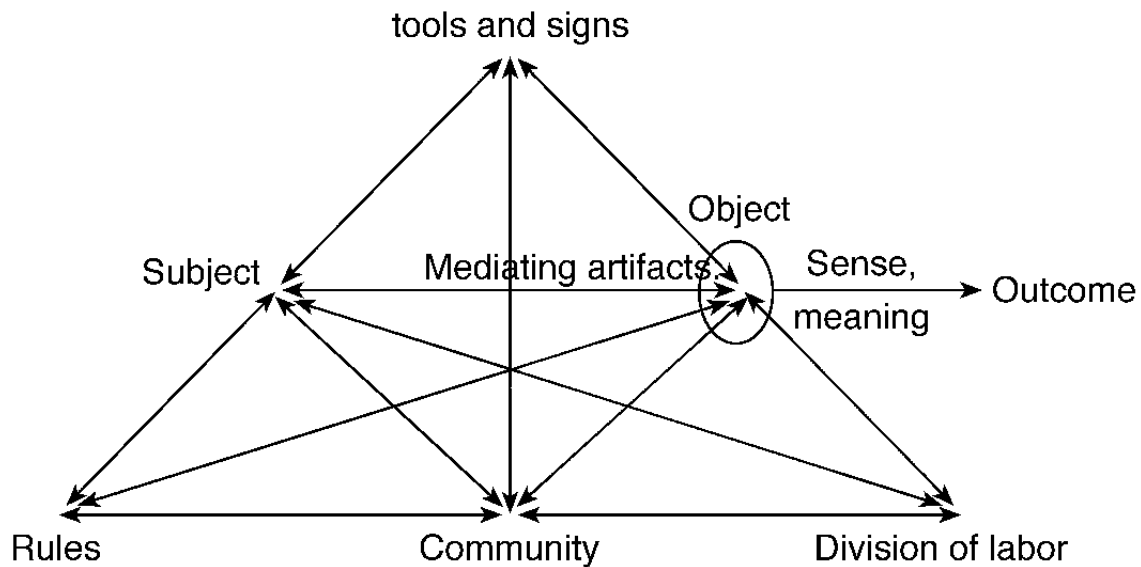


Figure 5: The structure of a human activity system (Engeström, 2001: 135)

In this chapter, I will first demonstrate how women utilize their agency and make choices about well-being for themselves and their children. I argue that women’s choices are influenced by many factors, and that women often move between different knowledge and activity systems. I show how the two interacting activity systems of biomedical knowledge and traditional healing and two trajectories of knowledge reproduction help transform women’s choices around childbirth, and that “boundary workers” help to narrow the divide between the two knowledge systems. I then illustrate how women’s choices are constrained by several factors including unequal and gendered power structures and are subjected to the patriarchal system. Next, I show how there are several ways that women are able to resist the patriarchal. Finally, I demonstrate how indigenous knowledge practices are integral to individual and collective well-being and identity.

1: Women’s Agency and Choices around Well-being: Two Interacting Knowledge Systems

As described in the previous three chapters, many women comply with cultural and social expectations and uphold the gendered roles and divisions of labour within the structures of their families and community. However, while adhering to these rules and values, women are also using their agency and making choices about their personal well-being and the well-being of family members, especially their children. Surfacing as well is that there are many factors influencing the choices women make, where they often move between different knowledge and activity systems, which is a reflection of a seemingly “hybrid” landscape within which they live their lives. What becomes evident too is that the social structure of the community is constantly shifting and reshaping as it is being reproduced. Various activity systems are overlapping and interacting with one another (biomedicine, indigenous practices, formal education, the church), and macro and micro influences and knowledge systems are weaving their threads into the fabric of life, simultaneously. As women cultivate their well-being they make various decisions about what is best for them and their offspring.

Below is a diagram that illustrates how women may be influenced by overlapping activity systems present in the community:

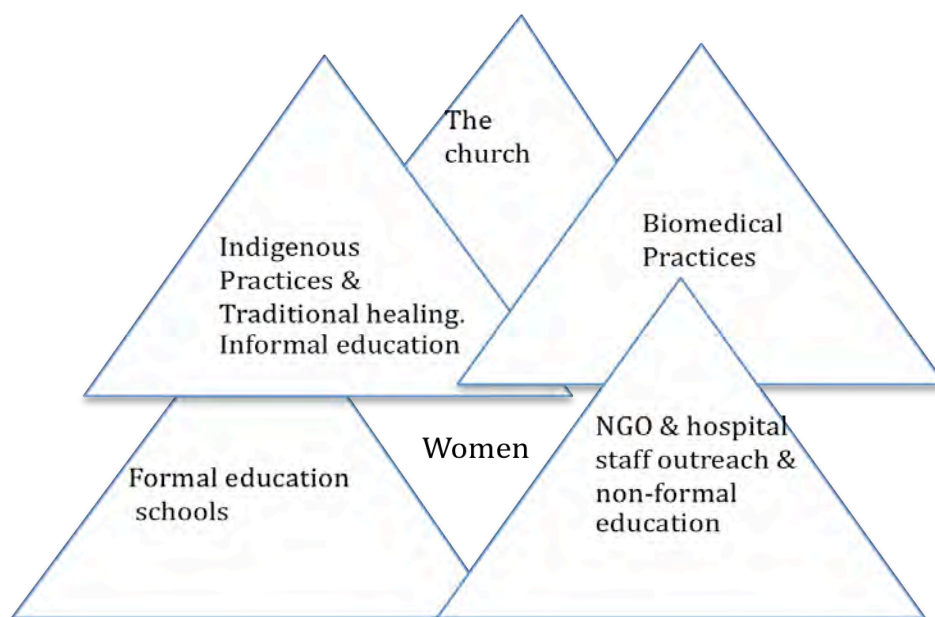


Figure 6: An example of overlapping activity systems

These overlapping activity systems affect different women in complex and different ways. The interplay within and between the activity systems suggests that there are ongoing negotiations and compromises as well as multiple points of view making up the complex social structure of village life. The women therefore live their lives in relation to all the complexities offered by the overlapping activity systems, not as separate entities that they choose and interact between, but as multiple strands that are woven together in the “meshwork” of their lives (Ingold, 2006: 13). As the women live their lives and make their choices regarding well-being, they are “threading their own paths through the meshwork and contributing to its ever-evolving weave” (Ingold, 2006: 14).

Moving Between Activity Systems

In the next section, I will show how the two activity systems of indigenous traditional healing and biomedical healing interact with each other within the social structure of the community and how they collectively have helped transform the choices women make about their well-being, especially around childbirth. I will also show how within these activity systems there are two trajectories of knowledge

reproduction, which help to influence the women's choices. I use the term "trajectory" to mean a directional flow of knowledge into the community. One trajectory is of "Western" knowledge practices such as biomedicine that are mostly formally reproduced, for example, via medical interventions, formal education and texts, although some biomedical knowledge is reproduced in non-formal ways through nurses or outreach education with NGO workers. The other trajectory is of mostly indigenous knowledge practices, which are reproduced informally. Both these knowledge trajectories interact and intertwine, presenting a "smorgasbord" of possibilities and options that the women in the community can choose from in order to cultivate, sustain and restore their health and well-being.

I will examine the internal relationships of the two interacting activity systems of indigenous healing practices and biomedical healing practices to help surface the aspects that may appear to be invisible, and to gain a better understanding of the relationships within and between the various components of these systems. The interrelationships are always examined between three aspects of an activity system, at one time, for example, between the Subjects, Tools of Mediation and Division of Labour.

Two Healing-Oriented Activity Systems Sharing the Same Object: Biomedicine and Traditional Healing

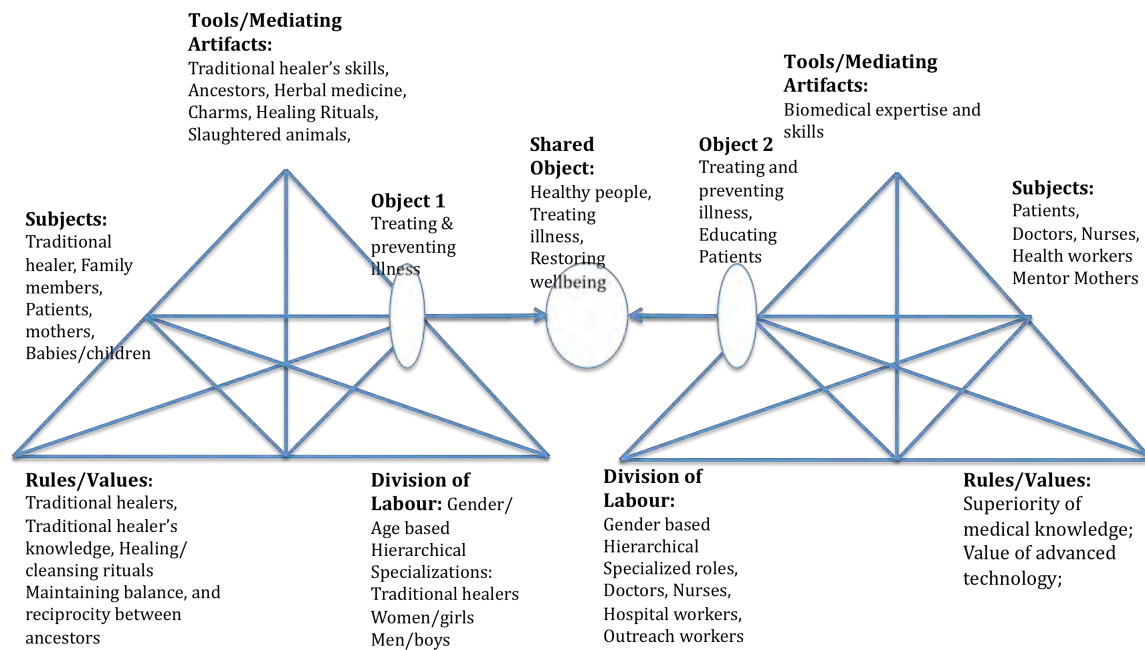


Figure 7: Two activity systems sharing the same object (Adapted from Engeström, 2001)

Many changes have taken place across time and space and within the historical landscapes of people's lives in the rural Eastern Cape, and particularly of those people living in the location of Mzingisi. Increasing global awareness and global influences such as new roads and access to technologies, such as social media, have made their way into the everyday lives of many community dwellers, thus influencing cultural change and transformations. Influences and changes such as these also influence people's values, which continue to shift as the various transformations take hold within the community, manifesting in seemingly more opportunities and possibilities to shape one's life. This seems to be the case with regard to health care and the options available from two healing systems. The focus of both biomedical and traditional healing practices is to prevent, treat and cure illness and disease, with the overarching goal of saving lives and restoring well-being.

As was evident from the descriptions in Chapters Five and Six, women move between knowledge systems and utilize both traditional healing methods and biomedicine to optimize their health and well-being. Paralleling the values of many people, who use both biomedicine and traditional healing, are also the two traditional healers I interviewed. They both had utilized biomedical services when they could not treat patients with traditional medicine, and in such instances, referred them to the hospital. This parallel use of healing systems could be in response to doctors and outreach workers educating patients, households and traditional healers about the dangers of prescribing “Xhosa medicines” to very young children and babies, or to people who have TB or HIV. As such, the divide between the two activity systems become narrower and in some cases overlaps.

Due to the hospital being at the centre of the community, it plays a major role in influencing people’s choices around health care and their well-being. Some of these choices may be related to the 24-hour caesarean section service at the hospital, the decreasing mortality rate, or the availability of ARTs for HIV patients. Women are being shaped by the knowledge they gain at the hospital, to the extent that it has now become the norm for them to deliver their babies there rather than at home, where they would have previously relied on the knowledge provided by elder women and midwives. While being shaped by changes and transformations in the social structure, they are at the same time shaping the social practice of childbirth within the community. This is an example of social reproduction, the process that Giddens terms “Structuration”, where there are “recurrent social practices” and “transformations” (Giddens, 1991: 203). From the perspective of Lave (1991), the women have become part of the “community of practice of hospital birthing”.

Following is an example of how the two activity systems of well-being interact and play a role in changing the landscape of health care choices for women.

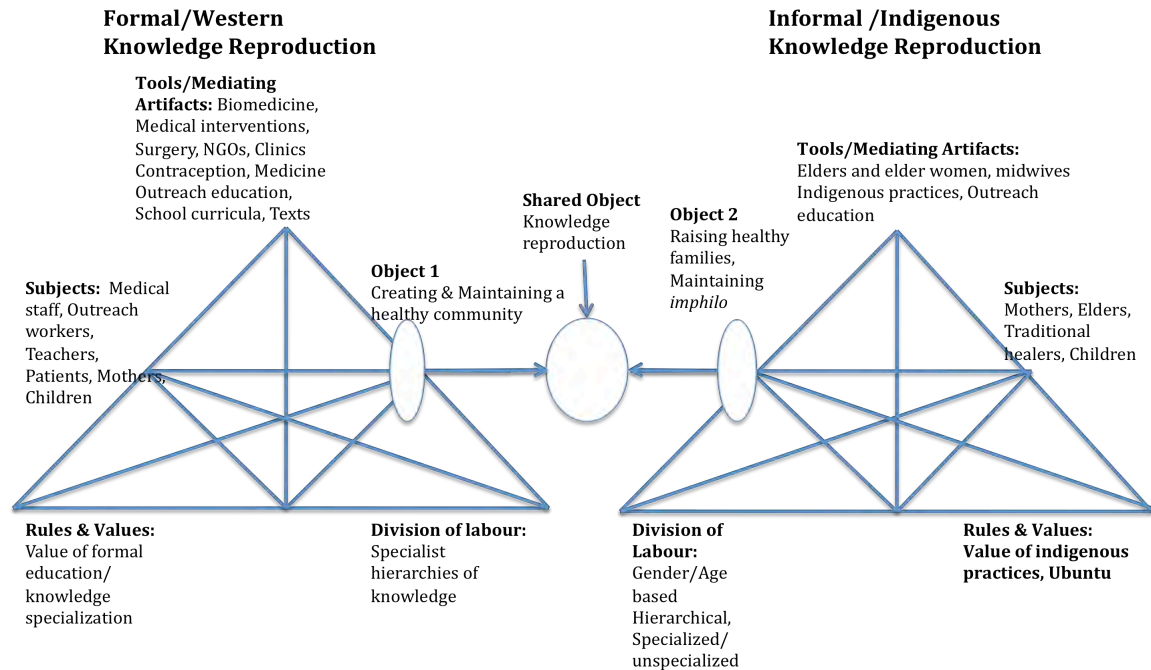


Figure 8: Interacting knowledge systems provide more choices for women’s well-being (Adapted from Engeström, 2001)

Engeström (2001) describes this type of phenomenon as a cycle of “qualitative transformation”, where contradictions within the activity system (issues or tensions arising from childbirth practices, e.g. high perinatal mortality rates and insufficient antenatal care) have been aggravated and individual participants begin to move away from the established and historical norms (giving birth at home). This can also be the result of a deliberate “collective change effort” (Engeström, 2001: 137) such as was made by the hospital staff to reduce the mortality rates and provide a better quality of care for their patients (Gaunt, 2010).

The hospital, however, does not stand alone, and has also built its reputation through collaboration with the NGOs who do continuous outreach in the community, often as boundary workers, helping to narrow the divide between the two knowledge systems and facilitating women in moving between the two systems. As such, it is the interconnectedness of the activity systems that assist in this transformation (Engeström, 2001). It is partly through this outreach and non-formal

education that the trajectory of biomedical knowledge has been reproduced very visibly, while the trajectory of indigenous knowledge practices has, on the surface, remained fairly invisible.

The Intersecting Systems of Knowledge

What has become evident from the data in Chapters Five and Six is that the reproduction of knowledge regarding health and well-being seems to follow two distinct trajectories. First, there is the trajectory of biomedical knowledge brought about by the presence of the hospital and health care facilities, through specialized knowledge such as the comprehensive specialized knowledge of medical staff who provide direct care to patients. This also includes education on a one-to-one basis such as administering medications correctly. There is also the system of outreach education and health care delivered through the various clinics and NGOs affiliated with the hospital, both in the immediate and outer communities. Then there is the trajectory of traditional or customary knowledge reproduction. This knowledge is dynamic knowledge that continues to be reproduced in conjunction with the varying socio-cultural contexts present in people's lived lives. Unlike the biomedical trajectory, which is prominent and is articulated via formal and very visible means, the indigenous knowledge trajectory is less visible and is reproduced via non-formal and informal means.

As such, there are two activity systems of knowledge reproduction sharing the same goal or two modes of knowledge reproduction actively being reproduced at the same time. As these systems or trajectories of knowledge are working simultaneously within the social structure of the community, they overlap and knock up against each other on an ongoing cyclical basis. This could be, for example, when an indigenous practice reinforces the patriarchal through the division of labour in the homestead and community; however in school, information in a textbook may suggest different divisions of labour and values. Another example could be when a woman receives treatment to become pregnant from a traditional

healer, and then receives information about exclusive breastfeeding from a nurse and outreach worker after she has given birth to her baby at the hospital. Both trajectories are reproducing knowledge and may complement or contradict one another. Having two systems of knowledge reproduction has transformed the health and well-being possibilities for women in the community because there is more information circulating, which results in there being more knowledge reproduction, more influences and ultimately more choices available.

An example of interacting activity systems is demonstrated in the diagram below:

Activity Systems interacting with each other as they reproduce knowledge

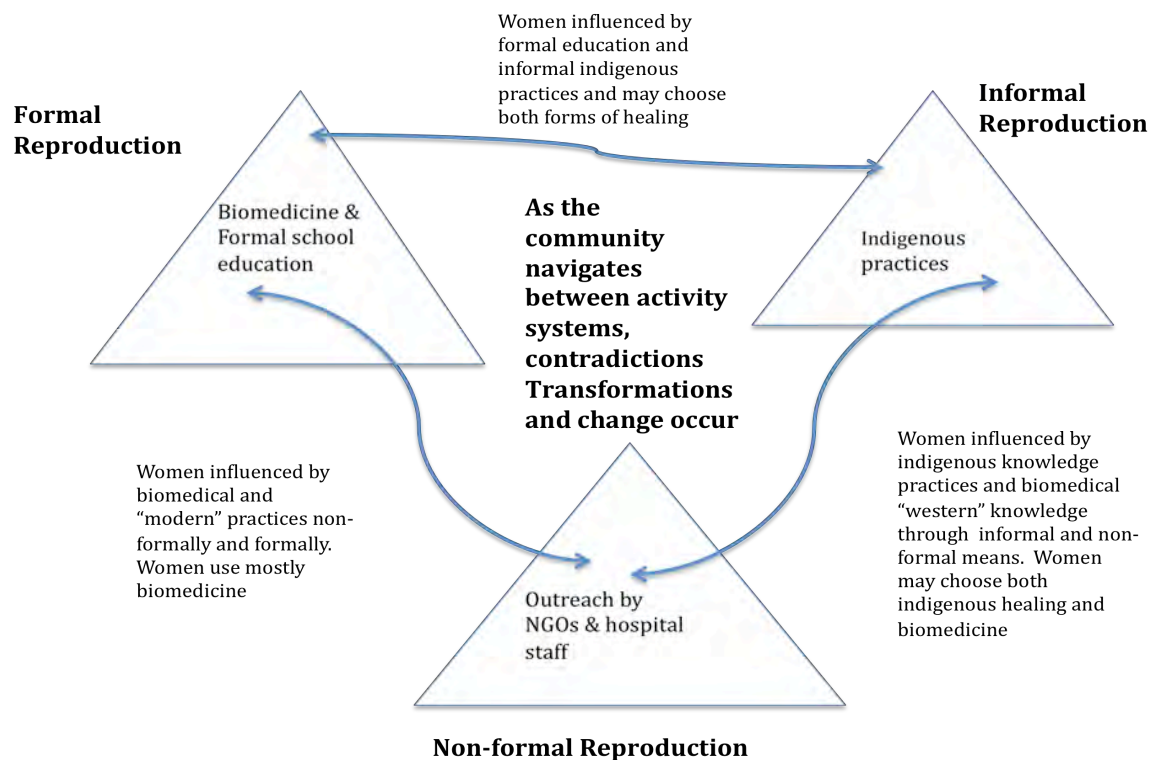


Figure 9: Interacting activity systems

As the knowledge is reproduced along different trajectories, simultaneously, "boundary workers" help the boundaries between the different knowledge systems

to get narrower or become blurred, thus causing the knowledge systems to overlap. I posit that the point at which the overlapping takes place, transformation and change may occur. While this is an ongoing and gradual transformation across time and space, at some point the change may become more permanent and becomes the “cultural norm”. This perhaps explains why in this research it was found that women almost exclusively chose to have their babies at the hospital rather than at home.

The diagram below illustrates these overlapping activity systems of knowledge:

As the boundaries between knowledge systems are brought closer together through “boundary workers” the systems transform and sometimes overlap causing a major transformation over time and space.

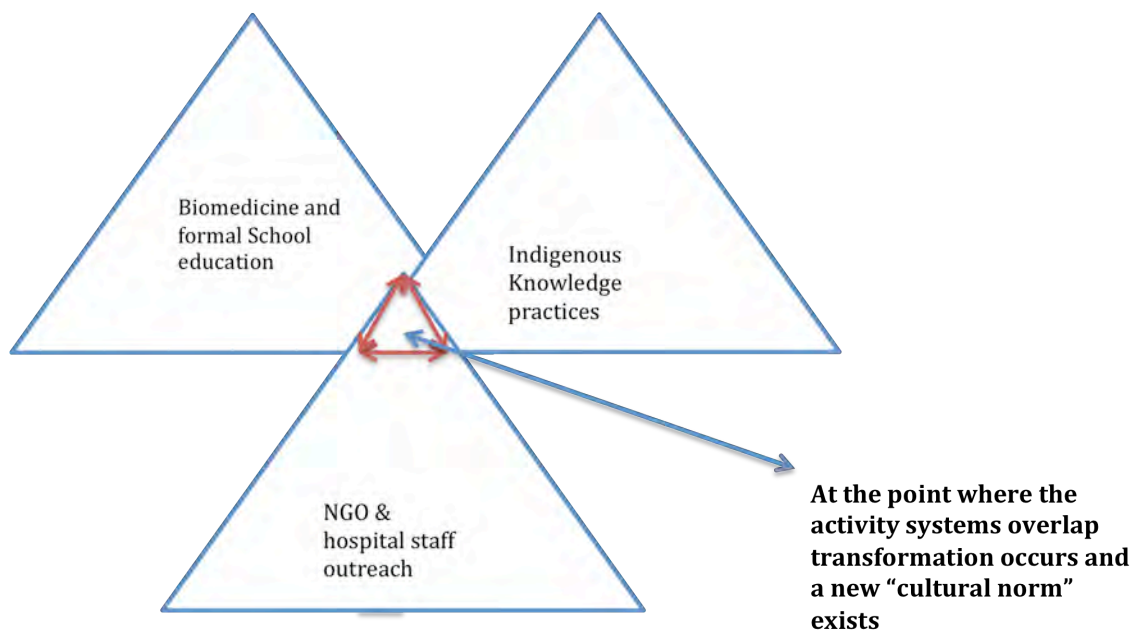


Figure 10: Overlapping systems of knowledge

Boundary Workers and Transformational Influences

The NGOs present in the community have been able to influence and change some of the dynamics within women's lives and some of the choices women have made about their well-being for various reasons. It may be that life becomes more hopeful with the extra support the outreach workers provide, or because women may become more empowered with the knowledge they gain from the different kinds of support. I would speculate that these influences may lead to there being less reliance on indigenous knowledge and informal learning methods and more reliance on "westernized" and more formalized learning and education. This was particularly noticeable with the Mentor Mothers outreach. As more mothers are educated about exclusive breastfeeding, the importance of keeping up to date with immunizations, accessing the clinic or hospital if a child is sick, avoiding the use of contaminated water, providing regular nutritional meals, and having healthy eating habits, then possible conflicts between indigenous knowledge practices and more modernized and seemingly healthier practices are likely to arise.

As women utilize biomedical options while gaining knowledge from outreach services or from the hospital staff, they may feel tensions or caught between two health care systems and two systems of knowledge reproduction. An example would be women who use mix feeding methods rather than exclusive breast feeding, as was mentioned by some of the NGO outreach workers and young women I interviewed. The knowledge they gained from the hospital and outreach services may also contradict the knowledge they gain from elders, or other women at home, which could also be a reason why women move between the two systems of knowledge. It could also be because the hospital takes on the role of an "authoritative resource" that has the "transforming capacity generating command over persons or actors" (Giddens, 1984: 33), and thus causes the more visible and formal knowledge system to be more influential than the indigenous knowledge practices. For example, with regard to women's decisions about where it is best to

deliver their babies, the authoritative structure of the hospital and its trajectory of knowledge reproduction influence the women's choices about childbirth.

Constraints on Women's Choices

In addition to influences from the hospital, there are other macro and micro influences changing the structure of the community. In the past, children in this rural area were socialized within the confines of the homestead and surrounding homesteads, with limited influences from outside of the village community (Jansen, 1973; Soga, 1931). Prior to and during the apartheid era, outside influences came in the form of the church, particularly missions, which established religious institutions in the area, with the intention of Christianizing the population and providing limited formal education and health care services (Jansen, 1973). Since the apartheid era, the rural Eastern Cape has undergone changes influenced by a new and democratic political structure, global capitalism, diminishing migrant work opportunities, expansion in infrastructure such as upgraded and new roads that create access in and out of the immediate community to the outer and macro community, as well as influences from expanded technologies like cell phones, television and exposure to social media. Other influences such as government institutions (i.e. schools and government-run agencies), NGOs, and a very high incidence of HIV and TB (Gaunt, 2010), have all played a part in impacting the social structure of the community. The myriad changes and influences in a relatively short period of time have helped to fuel both contradictions and transformations in knowledge practices. This has manifested through shifts in how indigenous knowledge is perceived and valued, especially by the younger generation.

Young people, in their efforts to be part of the modernized world, are resisting many indigenous practices, particularly traditional healing. For instance, as one young woman said in an interview: "We don't believe in that stuff any more; it is only the elders who go to traditional healers." These contradictions and what are essentially changes in practice by young people, are actively transforming the social structure

and its institutions, because they are drawing upon and reproducing structural properties from wider social systems (Giddens, 1984: 24). While individuals cannot control the flow of knowledge being shared via the hospital, they are being influenced by it and the role the hospital plays in the social structure, and all the services that emanate from it, including health care and outreach and any education they receive. Therefore the hospital is able to influence women's decisions about their health and well-being.

The contradictions occurring between the indigenous knowledge practices and the biomedical knowledge practices may be both "constraining and enabling", in that they may support well-being or hinder well-being, which means that there are always tensions present, depending on the kinds of choices or decisions that are being made (Giddens, 1984: 25).

Constraints from the church

Adding to the influences from the hospital and its affiliates is the influence from the church. The community is deeply Christianized, and many of the people attend various churches in the area. Social expectations stemming from Christian beliefs are also woven into the fabric of everyday life. The Dutch Reformed Church at the centre of the community established the hospital as one of its missions in 1956, and although the mission no longer formally exists, the pastor's residence is still referred to as "The Mission" by people living in Mzingisi. Thus the activity system of the church overlaps into many of the other activity systems in the community, adding another layer to the complexity of living in a seemingly "hybrid" world.

While there is evidence of tensions existing between the teachings of some of the churches and traditional healing practices, what is also evident is the coexistence of both entities. This coexistence reflects both the indigenous spiritual beliefs and Christian beliefs that many people, young and old, value, as was demonstrated in Chapter Five by the two traditional healers who also held active roles in Christian

churches. It is also a reflection of the abundance of external and internal influences within the structural systems which continue to evolve and intertwine, shifting some of the existing rules and values in social reproduction. Furthermore, as with all social reproduction, there are intended and unintended consequences (Giddens, 1984), therefore some people in the community may want to be strategic about how they go about their personal business and their visibility concerning their beliefs, as this may affect how people view them and their families.

Constraints Influencing Personhood

The multiple beliefs and ways of being that exist within the social structures in the community inform how one navigates within and between various layers of the community social structure. Because much of life is lived collectively, individuals monitor their own personal actions as well as the actions of others, and are often discursively conscious of whom and what is being monitored (Giddens, 1984). This could affect how people relate to each other and how they view certain qualities or attributes that someone may or may not possess, which is also related to the lifelong development of personhood.

Individuality is usually based on the collective expectations of the family or clan's world-view, which is linked in some ways to the world-view of others in the community, and could also affect one's personhood. Therefore, for some, being seen going to a traditional healer or admitting that he or she believes in traditional healing could contradict their external and public persona (modern/Christian). This could also be an indication of being caught between two world-views. This is consistent with Taylor's theory of the "topographical moral self", when he states: "Our description of ourselves is inseparable from our existing in a space of moral aspiration and assessment" (cited in Christopher, 2007: 171), meaning that a person lives in a "topography" of moral characteristics that one works towards achieving through constructing or shaping one's self and identity. This was affirmed in an informal discussion with an outreach worker, who told me that many people

struggle with having to navigate their lives around encroaching modernity and the many influences it brings, including the education system in the schools and/or teachings from the church, simultaneously with practices of past and present cultural systems.

2. Remaining Subjected to the Patriarchal

Women's choices are also constrained by gendered power relations, poverty and limited material goods, which can limit their agency and choices within power hierarchies. Historically, men and women have held very different roles within family and societal structures, and many of the divisions of labour reflect power hierarchies, which are often based on patriarchy. In most homesteads, men are still privileged with decision-making and authority, compared with women, especially if they are the head of the household. This has meant that married women are under the authority of their spouses, particularly with matters concerning money or the development of the homestead, even if the men are working away from the area.

While several married women in this research disclosed to me that they could not make decisions without their husband's input and were frustrated by the constraints of the patriarchal system, I argue that one of the ways that the patriarchal system is strengthened and maintains the life it has as an authoritative structure, is through the act of marriage.

Strengthening the Patriarchal through Marriage

As was shown in Chapter Four, where two homesteads were joined through marriage, the bride moved from her parents' homestead to that of her husband's, to live under the auspices of her husband's family as a new wife and daughter-in-law. As a new wife, she intended to bear children, which is the expectation of her husband, her parents and her in-laws. Bearing children adds value to her role as a wife and mother. It also adds strength to the patriarchal system because children are a measure of value for the father and his ascending and descending patrilineal

genealogies. Having children also contributes to the father's personhood. In this sense, the act of marriage is a set of practices that strengthens and sustains the male dominated division of labour and patriarchal "rules" of the social system, especially if sons are born who continue the cycle of patriarchy and their ties to their male ancestors. White (2001) speaks about male personhood being built through the successes of future generations of males, their marriages and their male offspring, and also through the exchange of bridewealth cattle, or *lobola*.

Outlined in my descriptions about marriage in Chapter Four were the various steps taken in preparation for the marriage, including the important role that *lobola* played in the contractual relationship between the two families. *Lobola* is a means to patriarchal development through its role as a mediating tool, towards developing the husband's personhood. White explains further:

Bridewealth cattle clear the path that joins two separate homes in a relationship of affinity: the path on which the wife moves in the other direction, in turn, on her way to build a house for herself and her children in a homestead named for her husband. Marriage is thus an appropriation of exterior reproductive powers, turning them into bases for a sphere that is now embedded in the yard: a hearth, that is, where wifely works produce domestic futures that are eventually objectified in the personhood of patriarchs... (White, 2001: 467).

In his discussion of personhood and the role of marriage, White (2001) also argues that the development of personhood through the "circulation of bridewealth" is often dependent on the wages that men in rural areas received or will receive for doing migrant work elsewhere. This implies that the apartheid regime also played a significant role in how patriarchies were developed and maintained:

The work of rural domestic reproduction in its patriarchal form was dependent on the capacities of adult men to integrate the proceeds of their rural-urban travels with the circulation of bridewealth that enabled them to encompass the domestic work of women. (White, 2001: 468)

The above examples show how women remain subject to the patriarchal because they are "entrapped" within the rules and values that dictate their roles as married

women and the divisions of labour within the ecology of the homestead. Oyewumi argues that in the context of African societies, it is possible that married women do not all see themselves as mere “wives of the patriarchal”, but rather identify as “mothers” within a collective social structure of mothers, fathers, men and women, with their identity as “wives” being a temporary configuration on the way to motherhood (Oyewumi, 2001: 1097). Such a portrayal implies a more powerful self-identity as wives and mothers. This leads me to argue that while there may be married women who do not see themselves as “victims” of the patriarchal, there are also women who are not content with the position that married life has dealt them, and consequently feel they have no voice and have limited power under the weight of the patriarchal.

Although the system of marriage and its strengthening of the patriarchal may have served its purpose in the past, it could now be interpreted as being antiquated and an infraction on women’s personal rights as “modern” partners in marriage. This may be especially so given all the macro influences described earlier that seep into the landscape. In the context of this community, women were not considered as equal partners in marriage, and their roles as wives usually required them to be subordinate to their husband’s demands. Therefore power relations within marriages are usually male dominated. This became particularly evident when domestic abuse occurred in the community and women reported to some of the doctors that they were afraid of disagreeing with their husbands for fear of violence. An example of women being assigned little value, and male privilege being amplified, occurred when, tragically, a young teenage woman from the village was kidnapped by older men for marriage, known historically as *ukuthwala*. The resurfacing of *ukuthwala* is also thought to be one of the results of the collectively devastating impact HIV and AIDS has had on family lineages and clans (Malan, 2011), and is seen as a way to extend patrilineal lineages and strengthen the patriarchal system.

Resisting the Patriarchal

The patriarchal also remains strong outside the system of marriage as was shown in the descriptions and analyses in Chapter Six, where young women struggled in their intimate relationships with men and faced challenges in having control over their own bodies in terms of preventing pregnancy and HIV infection. Here, the gendered hierarchy of male privileging and dominance took precedence over practising safe sex, or women having a voice in the intimate aspects of their relationship such as being able to advise their partners to use condoms.

Amidst the controversies surrounding marriage, male dominance and the patriarchal, there are women who do not wish to be subservient to men and are choosing to live their lives differently, such as remaining single. As one woman told me in an interview:

I will never ever get married. Men are so abusive. They beat their wives; they sit around and do nothing and the woman has to wash dishes and cook for them. That's why I hate to get married.

In the context of village life, many of the roles and divisions of labour are still based on influences from the past, with gender delineations stemming from historical social structures, and some of the most prominent being connected to sacred spaces and kinship ties. Women who choose to live their lives differently are disrupting the patriarchal, while the community structure incorporates patriarchy into the tapestry of life.

These different ways of being reflect the transformations occurring in the social structure where women are questioning the cultural expectation of gendered divisions of labour and some of the dominating rules and values. Where the rules and values often dictate behavioural codes for different genders, the rules are not always fixed and tensions or contradictions can arise. Contradictions act as catalysts for change and development, and “are historically accumulating structural tensions within and between activity systems” (Engeström, 2001: 137). Often contradictions

motivate individuals within the activity system to question and deviate from the prescribed norms and expectations, causing change and transformation. “An expansive transformation is accomplished when the object and motive of the activity are re-conceptualized to embrace a radically wider horizon of possibilities than the previous mode of the activity” (Engeström, 2001: 137).

So while the patriarchal may be strongly embedded in the identity of rural village life, there is still room for transformation and change. Thus the women are disrupting the patriarchal through the body of the self and through the most intimate aspects of their bodies, one decision or choice at a time. These disruptions may be activated by women who choose to be sterilized in the hospital after giving birth, thus having some control over their bodies, or women getting contraceptive injections in secret from the clinic so that they can control their fertility. In this way, the women are showing how cultures are not stagnant entities, but are dynamic, traversing a trajectory that is constantly evolving and transforming over time, which in turn influences the activity systems within the culture. Reciprocally, activity systems change over time and influence and transform cultures.

It is perhaps also partially due to similar transformations that the culture of childbirth in the community has changed from one that took place within the domain of the homestead and the boundaries of patriarchal domination, to one where women are choosing to give birth to their babies almost exclusively at the hospital, out of reach of male dominance and within the auspices of female autonomy. At the same time women are rejecting male domination and resisting some patriarchal rules and values, they are also choosing to actively participate in indigenous knowledge practices that support well-being.

In the next section, I will show how indigenous knowledge practices surrounding well-being are still valued and integral in the meshwork of people’s lives.

3. Changing Social Contexts and Structure: Reproducing Indigenous Knowledge Practices for Well-being

While tensions may exist within the community between indigenous and “Western” practices, women still use their agency to decipher what works best for them regarding their well-being. In so doing, many continue to perform rituals and ceremonies they believe are necessary for well-being. This ensures continuity in the reproduction of indigenous knowledge practices and contributes to individual and collective ontological security.

Rituals and ceremonies play a central role in the lives of most people who live in the area and are vital for maintaining the well-being of individuals, families and the community. They also provide the cultural base from where knowledge is reproduced during rites of passage for initiations and marriage, or to celebrate birth and commemorate death. They are also performed as mediating tools in times of adversity and aid in protecting against misfortune. All spiritual rituals and ceremonies involve the ancestors who provide protection and guidance for families and their well-being. Conducting rituals and ceremonies involving the ancestors also ensures continual reciprocity between the living and non-living, which aids in individual and collective well-being (Mndende, 2006). Additionally, many of the indigenous rituals and ceremonies involve the support and knowledge of traditional healers, who provide healing for illnesses or issues that they and their clients believe cannot be treated with biomedicine. Traditional healers utilize a holistic approach and access knowledge related to diagnosis and treatment through the ancestors and supernatural forces.

The descriptions and discussions in Chapter Four surfaced some of the dominant rules and values present within many indigenous rituals and ceremonies that have been reproduced over time. Many of these indigenous practices are defined or held within gender and age hierarchies, most of which have also been influenced by elements of modernity such as biomedicine, infrastructural development and

globalization. Values from the past are dynamic and evolving and therefore provide some significant influences, especially around practices concerning well-being. Many of these practices were found within the ecology of the homestead as well as during childbirth and childrearing. As was shown in Chapter Six, indigenous practices such as those surrounding childbirth and the newborn are still important in the lives of some women, even if they give birth to their children in the hospital. This is also true regarding marriage where the indigenous practices take precedence over a church or “white” wedding.

The embracing of “old” and “new” practices indicates that the lines between two activity systems are not so prominently separate, nor is life lived in “either/or” domains. Instead, it shows that life is lived in relation to all that exists within the social structure. Robbins refers to this as “indigenous modernities” where people integrate both “modern technologies and indigenous sociologies and cosmologies” into their lives (Robbins, 2003: 280). This way of being in the world is also aligned with Ubuntu ideology, which embraces the many different elements of society and recognizes the dialectical in human existence, and therefore transcends the binaries of “either/or” conclusions, and embraces “both/and” conclusions (Masina 2000: 170). In contrast to the notion of a “hybrid” society, in this interpretation, one knowledge system feeds into another and creates an additional space which allows for new possibilities to be produced, and the old and entrenched values of both systems to be questioned (Breidlid, 2013: 47).

Conclusion

In this chapter, I used Engeström’s CHAT as a heuristic tool to surface and analyze some of the seemingly hidden aspects within the descriptive texts of Chapters Four, Five and Six. Through CHAT, I argued that the interacting activity systems of biomedicine and indigenous healing and the two trajectories of informal and formal knowledge reproduction, together with other macro entities, simultaneously interact and overlap with one another and are influencing factors in the decisions

women make toward their well-being. Furthermore, CHAT provided a way to view dynamic activity systems that brought into focus that two interacting systems of health practices are operating side by side. However, the arrangement between the two health systems constitutes a division of labour rather than a clear conjunction of two knowledge systems. As such the arrangement between the two health systems would need further investigation to fully determine how the knowledge systems converge.

First, I demonstrated how women utilize their agency in the choices they make around individual and collective well-being. I then showed how the underlying influences of biomedicine and the knowledge gained through non-formal outreach and education, combined with improvements in the quality of care and the opportunity for some autonomy around the process of childbirth, collectively motivate women to almost exclusively choose biomedicine for childbirth.

I then illustrated that although there is a seemingly overwhelming presence and permanency of the patriarchal system, which is integral to the ecology of the homestead, it is being disrupted and transformed by some women who choose to live their lives differently. Moreover, the many women who are using biomedicine for childbirth are also resisting the patriarchal because they are by making this choice they are also de facto, choosing to birth their children outside of the patriarchal domain of the homestead.

Finally, I argued that despite all the macro and micro influences and overlapping activity systems, the performance of indigenous rituals and ceremonies provide individual and collective well-being and a sense of identity. Additionally, I argued that women live their lives within a world of “indigenous modernities”, rather than a “hybrid” society, embracing both the old and the new, and contributing to the ongoing meshwork of life.

CHAPTER EIGHT CONCLUSION

This study aimed to explore, analyze and conceptualize indigenous knowledge practices concerning the health and well-being of different generations of women, and how they are reproduced in a rural isiXhosa-speaking community. It also sought to identify and develop indicators of how the relationship between concepts of self, personhood and Ubuntu inform women's agency.

The analytical framework demonstrated that in order to elucidate the complexities surrounding women's well-being and how knowledge is produced, reproduced and even created anew, one had to consider the cultural-historical context, the macro and micro influencing mechanisms surrounding the knowledge-producing dynamic and the different levels of agency present in the context.

To frame the research, Chapter Four gave an in-depth description and interpretive account of the social structure of the community through the ecology of the homestead. This brought into view the nature of the physicality of the life women lead and the everyday tasks that were derived from indigenous knowledge practices. Furthermore, it brought to the surface the embedded nature of Ubuntu and personhood that underpins people's lives. Chapters Five and Six gave descriptive and interpretive accounts of well-being and the choices women made regarding health practices, childbirth and socialization, respectively. Each chapter addressed indigenous knowledge practices, biomedical health practices, choices made regarding health and well-being, and the ways in which knowledge was reproduced. The emerging analyses drew from the conceptual framework outlined in Chapter Two.

Chapter Seven gave an in-depth analysis using Engeström's CHAT to seek greater understanding of three themes that emerged from the initial descriptive and

interpretive accounts in Chapters Four, Five and Six. From those chapters, emerged important stories, which brought to the surface questions regarding why women chose almost exclusively to use biomedicine for childbirth; why women remained subject to the patriarchal system; and why women performed indigenous rituals and ceremonies to cultivate and sustain their well-being throughout their lives, especially with regard to marriage, childbirth and protecting their families.

Throughout this study it was demonstrated that the structure of the community exists as a constantly evolving complex entity, as illustrated through Giddens' (1984) theory of structuration. Giddens' critical theory helped to provide a framework for exploring the social actions and relationships within the context of the Mzingisi community and the ways in which human agency is critical in the kinds of choices the women make towards their well-being, and in the individual and collective reproduction of knowledge.

This chapter addresses the following findings to bring the research to a close:

- The ways in which indigenous practices and Ubuntu are integral to health and well-being.
- How women's knowledgeable relates to their choices around well-being.
- Knowledge reproduction and implications for curriculum.
- Application of this research.

The Roles of Indigenous Knowledge Practices and Ubuntu in Relation to Well-being

Across this study, many of the indigenous knowledge practices integral to health and well-being were found within the ecology of the homestead and in childbirth and socialization practices. Chapter Four demonstrated that many of the indigenous practices were carried out through the physical tasks essential for day-to-day living and were linked to individual and collective well-being. These practices included maintaining good relations with the ancestors through specific rituals and

ceremonies, which also played a central role in preventing and treating illness and misfortune. Also emerging from Chapter Four was the contribution that Ubuntu made towards well-being, and how it undergirds the ways in which many people live their lives. Ubuntu often manifests itself as a consciously motivated set of practices known as *ilima* that are enabled through compassion, caring and concern for one another and their ecological surroundings, which in turn helps to maintain collective well-being in the community. Furthermore, Ubuntu philosophy surfaced some of the ways in which indigenous knowledge practices are reproduced, and their relation to personhood and ontological security.

My findings in this research point to Ubuntu practices being intricately linked to the community's interest in and indeed desire for individual and collective well-being. This is an important social constant and, when seen against the complex pressures wrought on communities by modernity and the demands it makes on individuals and communities, certainly deserves much more scrutiny. What it is that sustains the desire within communities to maintain an intense sense of their need to connect within themselves is a question that this study forcefully brings to the surface. At the same time, it needs to be acknowledged that this desire and interest is never pristine, neat and innocent. The study found that there were real barriers that prevented Ubuntu from being practised. These barriers seemed to be linked to the struggle of living in poverty, with people carrying out acts that appeared to be informed by jealousy or malice, and which were often violent. These barriers were often expressed in the form of domestic violence and sexual assaults, which, I would suggest, stem from a build-up of internalized anger and pain, a devastating residue from years of oppression and disenfranchisement caused by the former apartheid regime. This was particularly evident for men, who were often stripped of their dignity and access to ways to provide for their families or a means to develop their individual personhood. Jealousy and violence might also stem from men feeling powerless and that the patriarchy is being threatened, an impact of modernisation, where women have been exposed to more formal education and different role models, and are often the sole breadwinners for their families. Women's roles and

how they approach tradition and customs may also have been impacted and changed as a result of living in poverty.

Women's Knowledgeability, Agency and Choices around Well-being

Chapter Five provided a detailed description and interpretive analysis of the different approaches women used towards maintaining their health and well-being. The analysis demonstrated that the choices they made were shaped by and drawn from the different knowledge practices available to them – indigenous healing practices on the one hand and biomedicine on the other.

This research demonstrated that women's knowledgeability was related to the multiple ways that knowledge was reproduced. By interacting within and between the various elements of the social structure and being exposed to multiple knowledges, it emerged that many women utilized both indigenous healing practices and biomedical health practices, and often moved between two systems of knowledge for their personal and families' health and well-being.

My findings in Chapter Six showed that much of the biomedical knowledge that was disseminated and reproduced in non-formal contexts was concerned mostly with childbirth and childrearing practices. Knowledge reproduction took place either within the hospital, at a clinic, or in individual women's homes, often through boundary workers who helped to bring two knowledge systems closer together, narrowing the divide between indigenous practices and biomedical practices. The non-formal reproduction of biomedical knowledge influenced many women in such a way that they chose almost exclusively to deliver their babies at the hospital rather than at home.

This can be explained in several ways. One reason why women are choosing to use biomedicine for childbirth, instead of indigenous practices, can be explained through Giddens' notion of the "reflexivity of modernity" (Giddens, 1991: 14).

Although the community in this research is set in a deeply rural area, the flow of modernity has continued to change the social structure and has in many respects “reorganized time and space” (Giddens 1991: 2). The women’s “reflexive selves” grapple with the influences that modernity has brought, and “contemplate all the counterfactuals” existing in their life-world, and so develop their knowledgeability from two of the most prominent aspects of the social structure: that of indigenous knowledge practices, which are oriented towards the past, and the other, of biomedicine, which is oriented towards the future (Giddens, 1991: 29). Furthermore, the hospital’s “institutional reflexivity” has improved its quality of care and outreach services, which has caused a “chronic flow” of biomedical knowledge into the arena of non-formal knowledge reproduction, via NGO outreach workers and hospital staff. This has resulted in biomedicine becoming increasingly visible, while the indigenous practices have become less visible. Consequently, the nature of modernity’s “disembedding mechanisms” has propelled the women away from the influences of “pre-established precepts or practices” such as those revolving around indigenous knowledge practices (Giddens, 1991: 20), and more towards the influences of biomedicine. This phenomenon seems to have influenced how traditional healers practise indigenous medicine with young children and babies where the healers indicated that they would refer them to the hospital rather than treat them themselves. This also brings to mind that within the domain of biomedicine, the biomedical knowledge system invariably acts as a hegemonic system of knowledge that views indigenous knowledge practices as inferior or inadequate, and keeps them as “subjugated knowledges” within the unequal power structure that exists between the two knowledge systems (Breidlid, 2013: 49). This could also explain why medical staff and NGO outreach workers, acting as boundary workers, are on the one hand narrowing the divide and bringing different knowledge systems closer together through their interactions and work with women in the community, but on the other hand, seem to be discounting some of the indigenous knowledge practices and regarding them as unhealthy or dangerous. An example of this is when women are told not to use indigenous “Xhosa” medicine for their babies and children, and that biomedicine is a safer alternative.

My findings also illustrated how women's almost exclusive use of biomedicine for childbirth is an unconscious form of resisting the patriarchal. By making choices about where to birth their babies, the women are exercising their personal power over their bodies and the bodies of their offspring outside of the domain of their male partners and the hierarchical division of labour within the homestead. In this sense, the patriarchal is being disrupted and the men remain outside of the space of the maternity and labour wards, which are primarily women's domains. Ironically, the women are not altogether escaping the patriarchal within the "male-dominated" system of biomedicine, which often fails to align childbirth practices with women's bodies and offer more comfortable ways to give birth. Instead, women in the hospital tend to give birth lying down with their legs in stirrups!

An explanation as to why women are choosing biomedicine for childbirth could be that women are living in a hybridized world and social structure, with one foot in the "traditional" and the other in the "modern". This is true in part if one considers that they are living within a multi-faceted social structure, which is influenced by different activity and knowledge systems. However, this interpretation might be inadequate as it suggests that the traditional is somehow stagnant and stuck in time and space, while the modern is progressing forward without the "traditional" being affected. Rather, the women are living in a social structure that is evolving on a continuum, where modernity is in action on an uninterrupted trajectory in time and space, much like a river flows toward the sea cutting its way through the layers of earth, creating new curves and bends. In its flowing it is ultimately forming a new and different version of the same river, which as it evolves, is aging over time. In a similar way, the "traditional" then is part of the social structure being produced and reproduced while being shaped by the flow of modernity. Thus the women are utilizing what modernity-in-action has to offer, which is a multi-layered strata of possibilities to enable their health and well-being. This could be likened to what Robins (2003) refers to as "indigenous modernities" where the binary lines between the traditional and modern have been transcended (Robins, 203: 266).

These different knowledge systems are however, sometimes in conflict with one another as was shown in Chapter Six, for example, where women struggled over not being able to control the use of condoms for birth control and to prevent HIV/AIDS. This resistance by their partners could be a way that men are resisting “Western science”, although a contradiction to this is that women are choosing “Western science” (biomedicine) for sterilization and permanent birth control.

As was illustrated in Chapter Seven (Figure 10), the overlapping activity systems transform the social structure and create new cultural norms. These new norms are constantly evolving and become visible when both the indigenous knowledge practices and the “Western” knowledge occur side-by-side, as with biomedical knowledge and indigenous healing practices, but also when knowledge systems merge together and in many respects exist within one another, as an indigenous innovation. One example of this is that the influx of social media has changed aspects of indigenous practices and ways in which people can relate and communicate with one another, and so social media is sometimes utilized at the same time as when indigenous knowledge practices are being utilized. This was the case as indicated in Chapter Five, when a traditional healer placed a special charm inside the cell phone of a client. Women therefore draw on aspects of modernity that have been infused into their lives and are meaningful and valuable to them, as are many aspects of the “traditional”. When women choose biomedicine for childbirth it is perhaps because it offers possibilities that are unavailable within the indigenous practices, and similarly, some of the indigenous knowledge practices that are utilized are unavailable within biomedical practices for some childbirth-related issues and post-natal care such as protective rituals, or making indigenous foods for their babies after they have given birth.

The women incorporate all of the complexities that have made up their lives into their decision-making around health and well-being. Their decisions are often derived from the ways in which they have been influenced by the social structure and how they have been affected by the many overlapping activity systems that

exist within it. The women make the choices they make because of their interactions within and between the activity systems in the world that is around them: the indigenous knowledge practices, the church, formal education and schools, the hospital, biomedicine, the outreach workers, all of which are part of the spiralling, changing and evolving social structure. Thus the women make conscious choices about their health and well-being based on how they live and view the world and on the level of value they place on the different practices they incorporate into their lives.

The findings in this research demonstrates how women's agency and choice-making extend beyond general theories of agency which are based on the individual rather than the collective. Here, women not only utilize both their individual agency but also their collective agency such as in the practice of Ubuntu and other indigenous knowledge practices that support collective well-being. Moreover women's power and ultimately their choice-making are drawn from the resources accessed through their individual interactions within the social structure but also from the collective resources they create and sustain among one another.

Knowledge Reproduction and Implications for Curriculum

Emerging from the analyses were ways in which knowledge was reproduced and the influencing factors on women's choices around well-being. Throughout this study, it was found that many of the indigenous knowledge practices were reproduced and learnt informally within communities of practice, similar to those theorized by Lave and Wenger (1991). The analysis demonstrated that knowledge reproduction was mostly successful when it occurred informally within the bounds of cultural and situated contexts. The gendered nature of the division of labour influenced how indigenous knowledge practices were reproduced and often learnt through participation in apprentice-type roles (Lave & Wenger, 1991). These knowledge practices were shown to be usually tacit in nature, and confirmed what Walters argues as being "integral to the social fabric that produces and reproduces

families and communities” (Walters, 1998: 436). It also emerged that intermediaries or boundary workers helped to blur the lines between the informal and formal knowledge systems so that biomedical knowledge was successfully reproduced via non-formal means. This often took place through planned, short-term activities such as those pertaining to health or nutrition (Walters, 1998).

In Chapter Six, my findings pointed to formal knowledge reproduction such as in formal education settings presenting a barrier to reproducing knowledge about health and well-being. This was evident in the reproduction of life-skills related to childbirth, childrearing practices and HIV prevention in teenagers and young adults. The knowledge that was reproduced through formal education was shown to be difficult to internalize and this could result in young adults and teenagers having unplanned pregnancies at an early age as well as putting themselves at risk for being infected with HIV. This might be explained in Fenwick’s (2001) terms, which suggest that young adults’ knowledge is more likely to be reproduced successfully if the learning is experiential and takes place within the experience, as opposed to from the experience (Fenwick, 2001: 35). For example, learning while doing practical, hands-on activities that are meaningful and relevant rather than learning about something out of context as is often the case when learning from texts.

Also emerging from this research was evidence that gaps in knowledge amongst young women could also be related to the fact that elders were relying more and more on the trajectory of formal knowledge reproduction, such as in school, to inform their daughters, rather than reproducing the knowledge themselves via informal means. The “disembedding mechanism” of formal education has therefore steered learners away from acquiring the indigenous knowledge practices that were so prominent in the past for older generations.

This research exposes the possibility of formal education contributing to what Lave (1991) terms the “anthropomorphizing of objects” (Lave 1991: 75), where people develop a sense of alienation from their knowledgeableability. In this case, it is learners

who are alienated from their community's indigenous practices, and their sense of personal power and identity as knowledgeable beings is denied. This phenomenon is often concentrated in entities such as school systems and workplaces. However, a contradiction also exists because institutions like these are often also viewed as places where knowledgeability is encouraged. This is perhaps summed up through Lave's words, when she states:

There is a paradox here. It is exactly in those organizations in which control through the narrowing, trivialization, and decomposition of full participation is most common – in schools and workplaces – that learning is most often an institutional motive and yet, by the argument here, most likely to fail. On the other hand, conditions for learning flourish in the interstices of family life, in the participation of children in becoming normal adults (Lave, 1991: 78).

Other factors influencing gaps in knowledge seemed to stem from divisions of labour, age and power hierarchies. This was evident in the rules and values regarding what can be disclosed between younger women and their elders, especially with regard to their sexual activity and accessing contraceptives. One of the reasons that the knowledge young women acquired in school was not discussed with elders at home seemed to be related to the cultural expectation and necessity for young women to show respect towards their elders. This is what Giddens (1984) terms as "Practical Consciousness", where agents possess the knowledge about what they can do but are limited by what they can say about it.

The gaps in knowledge reproduction found in Chapter Six regarding pregnancy, childbirth and HIV prevention, illuminated the complexities surrounding these issues, which are sensitive in nature and are not handled well inter-generationally. They also reflected similarities to extensive research by Delius and Glaser (2002), who argued that there is a systematic, historical archive of incidents that has aided in shaping the knowledge gap, stemming from European conquest, influences from Christianity and shifting spiritual practices, influences from migrant work, and the impact of AIDS. In other words, there were many influences stemming from the flow of modernity and overlapping activity systems that have shaped how knowledge is

reproduced. This includes the unintended consequences such as school curricula in the South African education system remaining under the auspices of a hegemonic scientism, which fails to interrogate its own historical archive and merely tolerates different knowledge systems such as indigenous knowledge, which results in learners facing potential alienation from this indigenous knowledge (Soudien, 2013).

While my findings revealed that there are some gaps in knowledge reproduction, more questions need to be asked and deeper investigations need to be made to fully understand the complexities surrounding the social structure and nature of knowledge transmission between generations or within a generation. This could include investigating further issues related to age and gender hierarchies, converging cultural clashes, and specific problems related to formal learning.

Application of this Research

This study contributes to theories about knowledge and how knowledge is reproduced. It also shows that indigenous knowledge practices are integral to the social structure and the integrity of the community, where they exist, and that the practices of the community facilitate knowledge reproduction. Indigenous knowledge practices are woven into the fabric of life and are reproduced through the skills and tasks needed for everyday living and which are intricately related to individual and collective well-being. Indigenous knowledge practices are also integral to collective and individual identities, as suggested by Lave's (1991) idea of how a community is dependent on the participants' co-construction of its identity, which in turn sets the foundation for individual identity.

Findings from this research can be applied to how educators view knowledge and knowledge reproduction, especially with regard to informal learning. This research highlighted that indigenous practices were learnt and mastered through informal physical and spiritual performance and were situated in "communities of practice"

(Lave & Wenger, 1991: 29), whereas such knowledge was more difficult to reproduce formally. This points to formal knowledge reproduction found in educational institutions being incongruent with the way in which indigenous knowledge is reproduced, which in turn suggests that for certain kinds of learning and knowledge reproduction to be successful, there should be more informal and contextualized learning opportunities provided for learners.

An important future study and extension of this research would be to create a health curriculum that offers informal learning opportunities that are culturally congruent and relevant for learners. This curriculum would need to embrace both indigenous knowledge practices and modern science and be relevant for young people who are growing up in a social structure that is simultaneously embracing a modern global society and indigenous ways of knowing. A new curriculum could also present an opportunity for educators to interrogate their own pedagogies and school curricula, and reassess their relevancy.

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APPENDICES

Appendix A

Record of Fieldwork 2011-2012

Observations

Observations took place throughout 2011 and 2012. The majority of observations were as a “participating observer” where I participated in aspects of everyday life and recorded what was going on around me. There were times when I was a “complete observer” where I observed from a distance with little interaction or participation. Observations were recorded by making field notes in notebooks and taking photographs.

Events Observed

- Observed official opening of the road. (May 14, 2011)
- Went on community boundary walk. (May 20, 2011 and May 21, 2011)
- Observed traditional healer #1. (May 28, 2011)
- Observed ritual cleansing for wedding. (May 28, 2011)
- Observed traditional healers’ meeting. (May 31, 2011)
- Observed the preparation of Umqombothi. (August 3, 2011)
- Observed wedding ceremony. (August 20, 2011)
- Observed maternity ward round with Doctor Gwen. (September 4, 2011)
- Observed tubal ligation in Operating Theatre. (September 5, 2011)
- Observed community gardener in paediatrics ward. (September 6, 2011)
- Observed community gardener at homestead. (September 26, 2011)
- Observed NGO outreach worker on mothers’ home visits. (October 26, 2011)
- Observed NGO outreach worker in maternity ward. (October 28, 2011)
- Observed Imbeleko ritual. (November 9, 2011)

Observed community gardener's homestead. (November 11, 2011)
Observed Caesarian Section in operating theatre. (November 22, 2011)
Observed traditional healer#2 and divination. (November 24, 2011)
Observed early childhood education advocate on home visits. (May 11, 2012 and August 24, 2012)

Field notes and Reflections of Observations

There are 250 pages of handwritten field notes and reflections that were recorded from observations

Photographs

There were more than 200 photographs taken.

Interviews conducted, recorded and transcribed

A total of seventeen individual interviews, one group interview and one focus group were conducted.

Chronology of Interviews

Interview with retired mineworker, May 20, 2011.
Interview with NGO volunteer in ARV clinic, July 25, 2011.
Interview with elder regarding Umngcamo cleansing ritual, July 29, 2011.
Interview with young man, August 3, 2011.
Interview with elder regarding Imbeleko ceremony, November 9, 2011.
Interview with community gardener, Faseka, November 11, 2011.
Interview with traditional healer #1 November 23, 2011 and May 5, 2012
Interview with bride regarding Umngcamo cleansing ritual, November 30, 2011.
Interview with traditional healer #2 May 9, 2012 and August 15, 2012.
Interview with ARV counsellor August 9, 2012.
Interview with young mother, Lungi, August 9, 2012.

Interview with young mother, Pumla, August 9, 2012.

Interview with young mother, Lindiwe, August 17, 2012.

Interview with young mother, Thandiwe, August 20, 2012.

Group Interview with Nomvula, Faseka and Zenzi, September 6, 2012.

Focus Group with six NGO outreach workers, September 14, 2012.

Interview Transcriptions and Field Notes

There are 134 pages of interview transcriptions, and 152 pages of typed field notes. .

Additionally, there are 40 pages of field notes and reflections recorded from interviews.

APPENDIX B

A sample of an interview transcription

File Name: WS650045.MP3sangoma (lizwe)

Interviewer: Yolisa

Transcriber: Thabisa Xhalisa

NB: Interviewer: Y, Interpreter: I, Participant: P, Transcriber: T

P: Bebefike izolo apha ababantu bezothenga i-airtime.

Y: Okay I don't understand. Anyway, how long was the training to become a Sangoma?

I: Uthi oluqeqesho lwakho lokuba sisangoma luthathe ixesha elingakanani ufundela ukuba sisangoma?

T: *How long did the Sangoma training take, how long did it take to study to become a healer?*

P: Awufundelwa.

T: *You don't study to become a traditional healer.*

I: Kaloku ngokuya wenziwa–

T: *I mean when you were made–*

P: Wenziwa ithwasa?

T: *Made an initiate?*

I: Eh [Yes].

P: Ndithathe ixesha elide ukusuka ku2001 ndizokwenza okokugqibela ukuthi ndithathe ishoba lokuthi ndiligqirha. Ngo2008, andithi Nosandiso umphumo wam ubongo2008?

T: *It took a long time from 2001 when I took ishoba [I don't know ishoba. It's probably a knob kierie] which confirmed that I'm a healer*

N: Mh.

P: NgesiXhosa ke kuthiwa kukukhutshwa ke wenziwe ke ukuba ugqibelele. Ndigqibile ngoku ukuba sisangoma ngo2008. Ndathatha ishoba lam, eliya. Nali liphantsi kwalanto.

T: *In isiXhosa they say you are been released when you have passed/finished. I became a Sangoma in 2008. I took my shoba, it's there, underneath that thing.*

I: Oh ukusuka ngo2001 ubuqeqeshwa?

T: *Oh so you were in training since 2001?*

P: Yah.

I: Oh! She was in training from 2001 then in 2008 she became a traditional healer.

Y: So it's a long training.

- I:** Yes.
- Y:** It takes a long time. I'm interested to know who comes to see you and who gets your help. Who comes to ask for help?
- I:** Uthi ke ngoku, ngabantu abanjani abazayo bazokufuna uncedo kuwe?
- P:** Abantu abazokufuna uncedo kum ngabantu abangaphilanga nabangaphilelwanga ngabantwana. Sendisitsho xa unyanga kaloku nje umntu ofuna ukuncedakala uyeza.
- T:** *People who come to me to seek for help are sick people and people with sick children. You cure/heal people who need help.*
- I:** She says it's women, men and children.
- Y:** And the children, do they come with their mothers?
- I:** Yes she's saying so.
- Y:** Tell me about the women that come to see you: what type of problems do they have?
- I:** Oomama abaza kuwe baneengxaki ezinjani?
- P:** Omnye umntu unengxaki yokufun' umntwana.
- I:** The other problem for women they want to conceive.
- P:** Omnye umntu unebhanti.
- I:** Others have shingles.
- P:** Senditsho zonke izigulo zomzimba nokuba unentloko ke iinto ezinjalo.
- I:** She says all the diseases like headaches. Nantoni enye (and what else)?
- P:** Unengxaki yomgqwaliso.
- I:** Bad luck.
- Y:** Can she help people with diseases like HIV/AIDS or Diabetes, high blood pressure?
- I:** Ungakwazi ukunceda abantu abanoGawulayo, abaneswekile, abanepressure.
- P:** Hayi abakhe bafike. Senditsho andikadilishani nabantu abanjalo qha kuphela ngumntu mhlawumbi okhohlelayo, i-TB le kade ibilula not le inzima, uyakhohlela, abenephika kodwa ndidibanise ukuba ahambe nogqirha, aze kum ahambe esibhedlele.
- T:** *No they don't usually come. I have never dealt with such people except that I usually get people who are coughing, with TB, the curable one and not the drug resistant one, the person coughs, has shortness of breath, but I make sure that the person sees a doctor as well.*
- I:** She says she has never dealt with people who are diabetic, pressure and HIV. She used to heal people who are coughing nantoni mama, abakhohlelayo (and what else, mama, those who are coughing)?
- P:** Yes i-HIV zange ndiyinyange.
- T:** Yes. I've never cured HIV.
- Y:** TB.
- I:** The old TB and she used to work with doctors.
- Y:** So they get one kind of medicine there and here. And if they get tablets from the hospital, what kind of things does she give them?
- I:** Ukuba pha esibhedlele bafumana iipilisi apha kuwe bafumana ntoni?

- P:** EzesiXhosa.
- T:** *You mean traditional medicine?*
- I:** Iyeza?
- T:** *Medicine?*
- P:** LesiXhosa.
- T:** *Traditional [medicine].*
- I:** Here they are getting Xhosa medicine.
- Y:** So that's from herbs and plants, from trees and barks?
- I:** Andithi zisuka emithini?
- T:** *Does it come from plants, isn't it?*
- P:** Mh-h. Lisuka phantsi.
- T:** *Yes, it comes from the ground.*
- I:** From roots.
- P:** Kodwa ke yimithi. Yinto enjengalangca, wombh' iingcambu. Ngumthi masitsho.
- T:** *But it's trees (or plants). It's like that grass, you take out the roots. Let's say it's a plant.*
- I:** From plants.
- Y:** She said that women come with problems like they want to conceive a child. Does she ever help people who are already pregnant to have a healthy pregnancy?
- I:** Uyeza umntu kuwe osele ekhulelwe qha efuna ukuphila kakuhle nje?
- P:** Mh [Yes].
- I:** Yes she used to help those people.
- Y:** And has she been successful with people who want to conceive?
- I:** Uyaphumelela ebantwini abanfuna ukuba nabantwana?
- P:** Mh [Yes].
- Y:** Do women ever come because they don't want to be pregnant and to get rid of the pregnancy?
- I:** Zange kuze mhlawumbi abantu abangafuni kukhulelwa kuwe okanye.
- P:** Abafuna ukuvalwa?
- T:** *Who want a vasectomy?*
- I:** Eh [Yes].
- P:** Hayi andikwazi nokuyenza loo nto.
- T:** *No I can't even perform that.*
- Y:** And with the young children, what problems do children have? Do they come?
- I:** Apha ebantwaneni, zingxaki zini abadla ngokuza nazo?
- P:** Ebantwaneni yinto engamandla. Ikhona lanto kuthi nguMgondo. Andiyazi ukuba bayibiza ngokuba yintoni na. Sithi thina luhanjo. La nto umntana ahambise agabhe ngentla, ayokozeke. Ndiye ndiyincede loo nto.
- T:** *With children, it's usually with serious ailments especially when a child has an upset stomach accompanied by vomiting. I usually cure such ailments.*
- I:** She said she used to help kids who are vomiting and diarrhoea.
- Y:** And she can give them something to stop the vomiting?

- I:** Uyabanika into yonqamla?
- P:** Mh [Yes].
- Y:** Like the other day I took a tablet from the hospital for worms because the children at the hospital had worms. So if I came to her for worms she could give me something?
- I:** Uthi ke ngenye imini waya esibhedlele ukuyakufuna iyeza leentshulube ngoba abantwana pha esikolweni babeneentshulube. Xa enoza apha kuwe angalifumana elo yeza?
- P:** Lozikhapha?
- T:** *[Medication] for taking them [worms] out?*
- I:** Ewe [Yes].
- P:** Ndinalo elokuzigoba zingajongisi iintloko phezulu ukuba makayeke ukulunywa.
- T:** *I have one for bending them so that their heads are not positioned upwards and to prevent stomach pain.*
- I:** She has no medicine for taking them out. She has the medicine for bending them.
- Y:** Oh okay! And then if they bend what happens?
- I:** Uthi ke xa zigobile ziye zithini?
- P:** Senditsho kaloku xa umntwana etyiwa zintshulube zijonga so. Athi xa ekhohlela ayikhuphe ngasentla. So ke ngoku zithe. Kufuneka zijonge ezantsi ukwenzela xa efumana elayeza lapha esibhedlele zikwazi ukuba ziphume.
- T:** *When the child has worms they face in this direction and that is the reason when she coughs they come out through the mouth. So which means they are facing upward. They should face downward so that when she gets medication from the hospital they could come out.*
- I:** She says maybe the child is cough, looking upward, he is coughing. Then he use that medicine to back them. Then the child is going to go to the hospital to get the worm out.
- Y:** And then they'll come out.
- I:** Yes they'll come out.
- Y:** How about newborn babies? Is there anything special to make them strong or to make sure that they have a healthy ... because they're so fragile?
- I:** Uthi ke apha ebantwaneni abancinci ikhona indlela mhlawumbi okwazi ukwenza ngayo ukuba bomelele babenempilo eright ngoba basengathi bangamqanda kuba basebancinci?
- P:** Umntana omncinci akanyangeki. Akufuneki mayeza siXhosa kakhulu apha kuye. Hayi akanyangeki umntana omncinci kakhulu. Loo nto sifundiswa ngayo ukuba umntana omncinci akufunekanga umenzele amayeza esiXhosa ngoba usemncinci kwaye amathumbu wakhe ase-
- T:** *A baby is not curable and you shouldn't give them too much traditional medication. No, babies are incurable. We are also taught not to give babies traditional medicines because they are fragile and their intestines-*

- I:** Okay. She says she can't heal the newly born because she's still young. The Xhosa medicine is not good for them.
- Y:** I know there's been some tension between the doctors and some healers that are giving young babies medicine, Xhosa medicine. So she knows it is not.
- I:** Utsho ke uthi uyayazi kukho ukubambisana noogqirha. Kukhona ukuthi oogqirha abayithandi– (do doctors not like–?)
- P:** Eh. Abayithandi.
- T:** *Yes they don't like.*
- Y:** How about the mothers after they had the babies, something to make them strong and to have maybe good breast milk, something like that?
- I:** Uthi ke apha koomama ke ngoku abagqiba kubeleka, nibanika ntoni ukuba babestrongo baphinde babenobisi oluninzi?
- P:** Umna ke andinalo iyeza lokumenza abestrongo xa egqiba kubeleka. Andialo elokumnika ubisi.
- T:** *I don't have medicine that will make them strong after giving birth. I also don't have one for breast milk.*
- I:** She says she has nothing to do with that.
- Y:** Do women come sometimes because they have Depression? Do you know Depression?
- I:** Yes.
- Y:** Like can she help people who feel depressed, sad and lonely and mental health problems?
- I:** Mhlawumbi umama abenoxinzelele, abenento ehleli apha entloko, ingqondo mhlawumbi ingabambi kakuhle, uthi uye ubanike ntoni? Masithi ngumntu ogula ngengqondo okanye uguliswa yinto ibiyenzekile.
- T:** *Maybe the woman suffers from pressure¹⁹, or something that sits in the brain, maybe she suffers from insanity, what do you give them? Let's say it's someone who mentally demented or she's sick because of a particular incident.*
- P:** Sistress. Umntu ogula ngengqondo andikadilishani naye.
- T:** *That is stress. I've never dealt with people who are insane.*
- I:** Masithi mhlawumbi onoxinzelelo.
- T:** *Let's say that she has pressure.*
- P:** Istress?
- T:** *[You mean] stress?*
- I:** Ewe. Masithi wahlelwa zizinto ide i-afekthe nengqondo yakhe.
- T:** *Yes. Let's say she had a bad life which affected her brain.*
- P:** Mh-m andikadilishani naye umntu onjalo.
- T:** *No I've not dealt with such person.*
- Y:** Are there special people who can deal with that?
- I:** Uthi akho bantu abanayo loo nto?
- T:** *So do you say that there are not people who are like that?*
- P:** Andika-ha-a.

¹⁹ The word, uxinzelelo she has chosen means pressure.

- T:** *I have– No.*
- I:** Amagqirha akwaziyo ukudilishana naloo nto?
- T:** *Are there traditional healers who who have dealt with such ailments?*
- P:** Yha akhona amagqirha awanyangayo amahlanya, umntu ogula ngengqondo, akhona.
- T:** *Yes there are those who cure/heal people who are mentally disturbed.*
- I:** There are those special healers that can heal it.
- Y:** The kinds of medicines that she prepares, she says they come from the ground. Does she have to mix them with water? Does she have to cook them to make tea? How does she use the medicines? Do people just eat the root in food? Can she talk a little bit about the kinds of medicines she makes?
- I:** Uthi urhalela ukhe umcacisele ngalamayeza owakhayo apha emhlabeni. Uwenza njani, mhlawumbi amanye uyawapheka?
- P:** Ayaphekwa amayeza, awucinge ukutyisa umntu iyeza lingaphekwanga. Uliyeka libile kakhuhle. Libile litsale.
- T:** *Herbs get cooked. You cannot feed someone a herb which has not been cooked. You let it boil, and let it simmer.*
- I:** Onke ayaphekwa?
- T:** *Do they all get cooked?*
- P:** Ayaphekwa onke.
- T:** *Yes all of them.*
- I:** She's cooking them all.
- Y:** And then does she for bad luck, like something like bad luck, what kind of medicine does she [use] to prevent bad luck or to protect somebody?
- I:** Izinto ezinje ngamashwa mhlawumbi okanye ukukhusela ilishwa lingezi kuwe usebenzisa ntoni?
- P:** Usebenzisa wona la akhiwayo asehlathini.
- T:** *You use the medicine [or herbs] that you get from the forest/woods.*
- I:** Aphekwayo?
- T:** *The one's that get cooked?*
- P:** Ewe ayaphekwa amayeza wonke ngoba nelokufutha liyaphekwa. Elingaphekwayo lelokuhlamba umzimba.
- T:** *All medicine gets cooked, even the one for steaming gets cooked. The one that you don't cook is the one for cleansing.*
- I:** Kaloku-. Some medicines are not going to be boiled. Some are going to be cooked, for some they just pour it in the washing basin.
- Y:** For cleansing.
- I:** Ebefuna umcacisele ezo zinto.
- T:** *She wanted you to explain those things.*
- Y:** Does she ever make something like a charm, something someone can wear for protection?
- I:** Uthi ke ayikho into efakwayo inxitywe mhlawumbi yenze ukuba ukhuseleke?
- P:** Sispaji. Ikhona.
- T:** *It's a [small] purse [that you can put around your neck or waist].*

- I:** Inxitywa ngabantu abanjani? Nam ndiyayinxiba.
- T:** *What type of people can wear it? I also wear it.*
- P:** Ngabantu abafuna ukhuseleko. Nawe ungayinxiba xa ufuna iyeza izinto ezimdaka mazingezi kuwe.
- T:** *It's people who seek for protection. You can also wear it as it prevents evil spirits from attacking you.*
- I:** Okay. There is that thing you can wear.
- P:** Kufuneka nindibhatale ngoku kudala ndithetha.
- T:** *You must pay me now because I've been talking for quite a long time.*
- Y:** And do people come because they have problems with love or?
- P:** Yho!
- I:** (Laughs) Uutsho ke uyabafumana abantu abazama ukufuna ukuthandwa okanye amadoda abo ayathandana emacaleni?
- P:** (Giggles) Kaloku kuyanyanzeleka umntu ndimlungiselele xa esiza ngoba nalapha ekuhlambeni kukhona uhlambele indoda yakho ikuthi ikuthande nomnye. Mh. Likhona elokuthi ubengumntu oright omhle. Akhona awokuthi ukhuph' ibhadi. Ngelixesha uhlamba ngeli yeza lokukhupha ibhadi, wenza ukuba ubenelakhi.
- T:** (Giggles) *It's important for me to help that person because sometimes you cleanse yourself to be loved by your man. There's another one for beauty. Others are for getting rid of bad luck to be lucky.*
- I:** She has those medicines for the luck, for the husbands who are cheating, for the work, andithi (isn't that so)?
- P:** Mh iwork.
- T:** Yes for work.
- Y:** So this is just a question. Do people come more because of illness or do they come more because of things like love or problems with husbands? Which does she do more?
- I:** Uthi aba bantu bakuzela kakhulu, ngaba bantu bagulayo okanye ngaba bantu baneengxaki zangezothando okanye zezelakhi?
- P:** Abezi kakhulu abantu bezothando. Senditsho iyalingana indlela yokuza kwabantu qha akhobantu lapha kodwa bayeza abagulayo, bayeza abafuna izinto zothando.
- T:** *People with issues of love don't come often. I mean the scale is balanced: I get sick people and those who have love issues.*
- I:** She says they are equal.
- Y:** Okay. Does she find people come and they don't find money to pay her? Does she see people when they don't have money to pay or must people always pay before she can help them?
- I:** Abantu xa bengenamali uyakwazi ukubanceda okanye abantu kufuneka bebhatala lonke ixesha okanye uqala ngobanceda ugqibele ngobabhatalisa?
- P:** Xa esiza esithi akanamali kuba exakekile, kuba ndingumntu, ndiyakwazi ukumnceda kodwa ngokwesithethe sobungoma njengokuba usiSangoma,

- uthunywe ngabantu abaphantsi, kufuneka umntu xa ezokufuna iyeza abeke imali kuba alisebenzi eli yeza kungekho mali.
- T:** *If someone comes penniless because of financial problems I do help, but according to tradition as a Sangoma, you have been sent by your ancestors. If someone comes to seek for medication, he/she should always pay because the medication does not work without payment.*
- I:** kodwa abantu bayayenz–
- T:** *But people–*
- P:** Bayayenza kaloku kuba ingabantu balapha umntu abaleke athi makandincede ubani uthi uyakhlukumeza kuba wenza okuba ababantu bakowenu bakusithele bangakutyhileli.
- T:** *Yes they do, but people here ask for help when they are sick [but without any form of payment] and that result to your own people [as in ancestors] becoming secretive to you.*
- I:** She sees someone, but it's not good because the medication is not working if there's no money. Zintoni kanene (what are those by the way)?
- P:** Zizinyanya.
- I:** They don't tyhilela [as in divining to] you.
- Y:** They don't take care of you.
- I:** Yes. They don't take care of you if you don't have money.
- P:** Ngoba kaloku njengokuba unxibe intsimbi uqashwe ngabantu bakowenu abafileyo bavuke bathethe nawe bathi, Nxiba into ethile nezintsimbi. Bakunike amayeza bathi lithathe ulisebenzise. So xa uphisa ngawo, bayakusithelisela.
- T:** *When you are wearing a beaded necklace it means that you are employed by your ancestors. They wake up and talk to you, instructing you to put on the necklace. They reveal to you the type of medication you should use. So when you just give them away, they retreat and become secretive.*
- I:** She's saying by wearing these beads, she's being employed by the ancestors.
- Y:** So if there's no money being paid then they are not happy and she can't help them as well.
- I:** Yes.
- Y:** Do you see regular people, the same people many times? For instance, do people come back to you because they know you are a good Sangoma?
- I:** Uthi abantu bayabuya kuba bebona ukuba usiSangoma esiright?
- P:** Bayabuya xa umntu ebencedakele. Xa iphinde yaphinda uphinda abuye.
- T:** *They come again if they have been helped [before].*
- I:** They come again.
- Y:** Do people come to her because they hear about her, you are a good Sangoma? How do people know who come to you?
- I:** Abantu beza njani ukuze bakwazi usiSangoma? Bakwazi ngokuva?
- P:** Abantu beza bakwazi ngokuba uSisangoma unxiba intsimbi. Athi ke xa enengxaki eze acinge ukuba awuyazi le nto. Athi ke akufika afike uyazi, umxelele, aphilile. Athi akuphila axelele omnye umntu athi ndincedakale phaya.

T: *People know that you are a Sangoma because of the necklace you wear. So when they have a problem they come to you thinking that you will not be of great help, but when you help and heal them, they spread the word and tell others that they got healed at a particular place.*

I: They hear from one another.

A voice: Makhulu

P: Yhe! [Yes].

V: Ndilambile.

T: *I am hungry.*

P: Khanihambeni kudala besombela.

T: *(Jokingly) You must leave now, they've been complaining for a long time.*

Y: If I have a real problem, I would come to you because you are always smiling and waving at me. She's a friendly person. She's welcomed me to her home.

I: Uthi xa enengxaki uzakuza apha kuwe kuba uyabona usiSangoma esiright esibulisayo.

APPENDIX C

Interview Schedules

Opening Questions for all interviews:

What is your name and surname?

How old are you or what year were you born?

Where were you born?

Where did you grow up?

How many years did you attend school?

Interview Guide to Young Mothers Regarding Childbirth:

I'd like to know about your experiences as a young mother.

1. Tell me what it was like for you when you first got pregnant.
2. How did you know you were pregnant?
3. How did you feel about being pregnant?
4. How did your family/mom/parents react?
5. What about your boyfriend and his family? Tell me what happened when you told him.
6. Were you worried about HIV/AIDS?
7. Tell me what you knew about pregnancy and childbirth before you got pregnant?
8. How was it the same or different when you realized you were pregnant?
9. What experiences did you have taking care of young children or babies before you were pregnant?
10. What did you learn about pregnancy at school?

11. What did you know about prevention of pregnancy?
12. Tell me some of the good things about being pregnant.
13. What were some of the difficulties/hard things?
14. Tell me about when you went into labor – how did you know?
15. Where did you have your baby? Who helped you?
16. Were there any special things you did to make sure your baby was healthy?
(food/drinks/church/traditional medicines)
17. Did you ever see a traditional healer during pregnancy or afterwards?
18. Tell me about any special ceremonies you have done to make sure the baby is healthy and strong.
19. Are you breastfeeding?
20. How long did/will you breastfeed for?
21. Are you still with your boyfriend?
22. Does he or his family support you?
23. What kinds of things would you tell your friends about being pregnant now that you are a mom?

Group Interview Guide

1. When did you come to this area?
2. How were things for young girls when you were growing up?
3. How is it different nowadays?
4. Why do you think things are different now?
5. Who influenced you the most growing up?
6. Tell me story about growing up – as a young girl or woman.
7. How did you find out about things like having a boyfriend/ marriage/ having babies?

8. Tell me about getting married – what were the procedures – negotiations/bride price – did you have a traditional/ church wedding?
9. Tell me about having your children. Where did you have them – at home/hospital?
10. Who helped you at home?
11. Were there any special things you did when you were pregnant to help the baby grow well? Foods/herbs?
What about to help you recover from the birth – food/herbs?

Interview Guide for community gardener

1. When did you come to this homestead?
2. Did it belong to your husband's family?
3. When did you first become interested in gardening?
4. How did you get to know about gardening? Who influenced you?
5. When I first came to your homestead, you pointed to the erosion, and asked me how it could be stopped – you were testing me – but you knew what to plant – why do you think most people do not know these things?
6. Tell me about your father gardening.
7. How did he get to know about gardening?
8. Was your mother ever involved in gardening?
9. Are your children interested in gardening?
10. What do they do on the homestead to help you?
11. Tell me about the gardening projects you have in the community. How many are there?
12. When did you first start the community gardening projects?
13. Why did you start the projects?
14. Who helps you with the projects?
15. How long have you been teaching people in the community about growing food and nutrition?

16. Tell me about the moms you talk to and teach about nutrition in the paediatrics ward
17. How do you think you make a difference by talking to these moms?

Interview Guide for *Imbeleko* Ritual

1. What is *Imbeleko*?
2. Can you tell me what must happen at *Imbeleko*?
3. Why is it performed/why do girls and boys have to pass through this ceremony?
4. In this case both a boy and a girl passed through *imbeleko* together – does this normally happen together?
5. At what age must one pass through *Imbeleko*?
6. Who attends this ceremony – who is invited and who must be there?
7. What role do the ancestors play?
8. What are the consequences if you do not pass through *Imbeleko*?
9. Tell me about when you passed through *Imbeleko* – what was it like for you?
10. How old were you when you passed through *Imbeleko*?
11. What about your brothers and sisters, did they have to pass through it as well?
12. How did you learn about *Imbeleko*? Who told you about it?
13. What must the family do to prepare for *Imbeleko*?
14. What must the boy or girl do to prepare for *Imbeleko*? Are there special things he/she must do?
15. Who advises them about what they must do for *Imbeleko*?

Interview Guide for *Umngcamo* Ritual

1. What is your name?
2. What is your age?
3. Tell me where you were born and where you grew up as a child.

4. I am here to ask you about the ceremony you went through a few months before you got married – what is this ceremony called?
5. Tell me about your experience.
6. Does every woman do this when she's going to be married?
7. When I came, it was part of the ceremony where you went from the hut in the blanket to the kraal; before that you were in seclusion. Is that correct?
8. How long were you in seclusion for?
9. How did you get food during this time?
10. When I came the other month, you went to the kraal; a traditional healer washed you with special herbs. Tell me about that. (What is the purpose?)
11. I left the ceremony because it was getting dark. What happened next after you were washed with the herbs?
12. The traditional healer was a man – why did your family choose this healer rather than a woman?
13. As a woman, you were allowed in the kraal – on this occasion, why was it okay for this, but not at other times?
14. How important are the ancestors in this ceremony?
15. When does the wedding begin? Is it immediately after you come out of seclusion?
16. Who told you about having to do this growing up – how do the girls find out?
17. Where did you stay that night?
18. Tell me about the wedding.
19. The gifts that you were given at the ceremony, are they for you or for the husband's family?
20. Tell me about *lobola*. Did your family receive *lobola* before you were married?
21. How long does it take to prepare for something like this?
22. The women that were there that day, were they relations or also people from the community?

Focus Group Interview Guide

Date of Focus Group:

Number of participants:

Introduction before questions were asked:

This is _____ who will be translating for me today.

I would like to learn more about what mothers do to maintain their health and well-being. I will be asking you some questions and whatever you answer is valuable.

There are no right or wrong answers.

Is it okay for me to record this? Your names will not be recorded.

Questions:

1. What do you think helps women maintain their health and well-being?
2. What do you think are the most important things to have a healthy life?
3. What are some of the things women here do to support the well-being of themselves and their families? Babies?
4. What are some of the issues in this community that stop women and their families from being able to have healthy lives?
5. Tell me about some traditional practices that support health and well-being.
6. How do traditional healers help women's health and well-being?
7. What kinds of problems do women go to traditional healers for?
8. Who influences women the most when it comes to their health and well-being? (Who do they learn from?)
9. What are some things that help women have healthy babies?

Appendix D

Informed Consent

AGREEMENT TO PARTICIPATE

PhD Research conducted by Yolisa Hobongwana-Duley
Exploring Indigenous knowledge practices concerning health and well-being

I am a student at the University of Cape Town conducting research over the next few months. I am interested in practices concerning health and well-being held by different women in this community. I would like to interview you and find out about your experiences and practices regarding health and well-being.

If I use this information in a publication or at a conference presentation, I will do my best to maintain your confidentiality by not using your name. Your participation in this research is voluntary and you are free to withdraw at any time without prejudice or penalty. This research is part of my PhD requirement at the University of Cape Town and is not connected to any other institutions or outside sources.

Thank you for your time. If you have further questions, concerns or would like further information, please contact me at 0724768905.

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Participant:

- I have been informed about the purpose of this research
- I understand that all the information I provide will be treated as confidential and will be reported anonymously
- I understand that I may withdraw from this research at anytime without penalty
- I agree to be interviewed

Signature of participant

Date