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ZULU RITUAL IMMUNISATION IN PERSPECTIVE

Frank Jolles and Stephen Jolles

Making incisions (*umgcabo*) and punctures (*ukutshobha*) in the skin for the purpose of introducing medication (*umuthi*, pl. *imithi*) into the human body is a widely used technique in traditional Zulu medicine. It may be ranked with the use of injections in Western medicine, with which it is often compared. Most people who have consulted a traditional healer, which includes the overwhelming majority of the urban and rural black population of KwaZulu/Natal, will have been treated with *umgcabo* or *ukutshobha* at one time or another. In its current form it is a potential route for infection by blood-borne pathogens, both viral, e.g. Hepatitis B (HBV), Hepatitis C (HCV) and HIV, and bacterial, e.g. staphylococci and streptococci. This brings it into direct conflict with modern medicine and by extension with government health policy. However, it is arguable that such was not always the case, rather that the present situation represents a misuse of *umgcaba* and *ukutshobha* which arose as a result of colonial legislation and attendant economic pressures dating back to the nineteenth century (Berglund, 1976: 190; Jolles and Jolles, 1998). These and other problems associated with traditional medicine, many of them equally sensitive, present the government with something of a quandary. On the one hand legislation leading to the 'full legal recognition of traditional healers as health-care professionals' and their integration into the state health-care system (*Natal Witness*, 5 August 1998, p. 5) is in the process of being drafted. On the other, the Minister of Health, Dr Nkosazana Zuma, has stated that traditional healers should be allowed to continue practising in a private capacity (which represents the *status quo*) but that they should not be taken into employment or paid by the national health service[1] (SABC TV2, 30 January 1999).

South Africa is something of a latecomer in addressing these concerns. The fiction of 'separate development' made it too easy for the pre-1994 government to avoid them. So all issues connected with the organisation and standardisation of traditional medicine, the training of practitioners and their integration into national health care provision were barely broached whilst most of the neighbouring countries of southern Africa were grappling with them.[2] Since then the problem has become ever more urgent in view of the inability of the

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[1] Compare Ngubane (1986: 203) for a similar conclusion.

[2] Compare Last and Chavunduka (1986) for contributions on Botswana, Malawi, South Africa, Tanzania, Zambia, Zimbabwe and a number of West African countries.

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national health service to budget for increasingly expensive care for victims of the AIDS epidemic,[3] leaving it to traditional healers to give such support as they can. We shall return to this point. There is one aspect in which Zulu medicine differs from that of most of its neighbours: the separation of the roles of the diviner-diagnostician (*isangoma*, (pl. *izangoa*) and the healer (*inyanga*, pl. *izinyanga*).[4] Over the last hundred years or so this relationship has been profoundly modified by colonial and post-colonial legislation. The practice of making incisions was probably the main area of overlap between the functions of the traditional *isangoma* and the *inyanga*, so a case study of this component of Zulu medical practice should help to clarify the nature and the implications of the changes that have taken place.

The custom of making incisions for medical, ritual and cosmetic purposes is widespread throughout Africa, and there has been much discussion of the risk of transmitting blood-borne diseases, particularly HIV, through such practices as scarification and circumcision (Caldwell and Caldwell 1994; Katz, 1989; Zavriew, 1994: 815). In many areas, including South Africa, this has led to the introduction of more hygienic practices, such as the use of new razor blades for each procedure. The effect of these practices on the transmission of diseases is difficult to quantify in an environment in which the diseases are endemic. It would require a prospective study in patients who were negative for HBV, HCV and HIV and subsequently became positive, with the ability to confirm that the source of the viral strain was the incision by polymerase chain reaction (PCR). However, the principle that this is possible is supported by many cases dealing with the transmission of HBV by needle-stick injury in Europe in which the source of the infection could be traced to particular carriers (Hibberd 1995: 22–31). At first sight, some of the findings of research in Africa may seem contradictory: for example, there appears to be a higher incidence of HIV in those areas in which male circumcision was not practised. This has some bearing on the present study. Male circumcision was abandoned among the Zulus towards the end of the eighteenth century. It was reintroduced by Josiah Shembe in the late 1930s, but only within his religious community. So most of the Zulus can be included in the risk category of those who do not practise circumcision. To our knowledge there has been no study investigating any difference in the incidence of HIV positivity among members of the Shembe Church and others. However, controlling for factors other than circumcision would be difficult. Rather than attempt a comprehensive review of the discussion surrounding the spread of blood-borne diseases through traditional medical techniques, the object of our research has been to

[3] In a review published in the *Financial Mail* (25 July 1997), 'AIDS costs multiply: study', Claire Bisseker quotes the Free State team leader Ntsiki Jolingana as saying, 'Services will not cope in the future and people will have to be cared for in their homes; we have to start preparing for that'.

[4] See also Yamba (1997: 205): there is 'an unclear distinction between "witchfinder" and "traditional healer" in the minds of the people'; in Chiawa, Zambia, both are called 'ng'anga'.

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present a regional perspective limited to rural KwaZulu-Natal. This seemed appropriate, as, according to official statistics, KwaZulu-Natal has the highest rate of HIV positivity of any province in the Republic of South Africa. In what follows we report in detail (on the basis of interviews) some of the practices of diviners and herbalists in their historical context and hope to demonstrate how the risk of infection has been increased as a result of the changes that have taken place.

CURRENT PRACTICE

The most common form of *umgcabo* involves making incisions a few millimetres long in the skin with a razor blade, usually a new blade broken in half for each patient. The incisions are made in a single session in the following places: on the forehead or on top of the head, at the temples, at the base of the neck, front and back, and then at all joints: shoulders, elbows, wrists and sometimes fingers; hips, knees, ankles and sometimes toes, and at the base of the spine. These are 'said to be the most vulnerable points through which evil elements enter the body. Hence in prophylactic treatments incisions are made on the joints in order to introduce medicine directly into points where the body is most at risk' (Ngubane, 1977: 25). The incisions consist of either a single cut or a pair of cuts next to each other. The healer rubs a preparation into each one, using his fingers. The preparations can vary according to the condition to be treated, but in practice any one healer tends to use the same *muthi* for all conditions commonly treated through *umgcabo*. It will contain a wide range of ingredients—typically between five and fifteen substances, mostly of plant origin, usually burnt and finely ground in an oily suspension. This mixture is normally kept in a plastic container and used repeatedly until it is nearly finished. It is then replenished with more of the same ingredients, which are mixed in with the old. The treatment takes five to ten minutes per person. It is administered both to individuals and to groups of people, such as households. It is clear that blood from the incisions can be transferred from one patient to the next via the healer's fingers and the *muthi*.

Umgcabo is used mainly as a protection against malicious spells cast by witches and sorcerers, harmful buried medicines (*umeggo*, *umbhulelo*), nightmares, particularly those caused by the ubiquitous river spirits *tokoloshe*, headaches and nose bleeding caused by the *impundulu* bird (an artificial creature used in witchcraft), and against lightning and bullets (often sought by taxi owners). But it can also be used to attract good fortune. It has to be applied at regular intervals; thus for lightning every five years is sufficient, whilst protection against gunshot wounds needs to be renewed every six months. The practice of introducing medication through cuts made in the skin with a razor blade is well documented for many parts of the southern African region. It was used by witch finders in Zambia to disable witches and potential practitioners of witchcraft from practising their art. This could involve entire village communities (Auslander, 1993: 172 f.). It is ironic that the witches whom this ceremony was intended to unmask were regarded as responsible for the growing AIDS pandemic (1993: 168).

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Recent reports in the media have also referred to its use in Zimbabwe (BBC, July–August 1998).

Ukutshobha is a form of injection using a porcupine quill or a sharpened bicycle spoke. The skin is punctured in rapid succession all down both sides of the body at intervals of 5 cm to 10 cm. This is painful and accompanied by profuse bleeding. At every fifth puncture the quill is dipped into a buck's horn or goat's horn containing the *muthi*, usually a stiff waxy paste, some of which adheres to the quill. It contains a different set of ingredients from those used for *umgcabo*. After use the quills and bicycle spokes are stuck into the paste in the horn and a stopper is placed over the opening. One such *ukutshobha* set will typically include two or three quills. *Ukutshobha* is used on individuals rather than on groups of people, but in the course of a day it will often be used on a number of persons consulting the healer. The horns are frequently lent out to third parties wishing to treat themselves and members of their families. 'It is easy to do. Anyone can learn it' (Nhlanhla Zwane of Mangweni, interview, 29 April 1997). It is clear that blood from the punctures can be transferred from one patient to the next via the porcupine quill and the *muthi*.

Ukutshobha is a therapy for existing conditions such as fainting, swollen legs, a feeling of tiredness, one-sided lameness 'when half the body is not working'. It can be applied to the inside of the mouth when there is paralysis of one side of the face. It can also be used against nightmares and madness. Many of these conditions are commonly associated with witchcraft. *Ukutshobha* works by letting the malignancy bleed out of the body. It is a form of purification. During the first session the blood that comes out of the punctures is often black. When *ukutshobha* is repeated the following day it has usually returned to its normal colour. This ties in with the symbolic use of colour in Zulu medicine, using black remedies to expel the ritual pollution caused by witchcraft and sorcery (*ukuhamba sinyama*) (Ngubane, 1977: 113–18). In that case it helps to explain why a porcupine quill, which is usually black, is used rather than a razor blade. So *umgcabo* is basically applied as a preventative treatment, whereas *ukutshobha* is a curative therapy. In both cases the prime function is 'to keep or restore order; the word commonly employed in this context is *ukuzilungisa*, to restore order where there has been disorder' (Ngubane, 1986: 192). In difficult cases both therapies are sometimes combined. For the treatment of AIDS one healer said he used *ukutshobha*, *umgcabo* and a medicine administered orally (Nhlanhla Zwane, 29 April 1997). Whilst *umgcabo* has been recognised and fairly widely discussed, *ukutshoba* so far seems to have eluded attention.

In the context of modern medicine these practices expose the patient to a number of risks. Firstly, the skin, an excellent barrier to infection, is breached, allowing the spread of bacteria both from the skin and from within the *muthi*. This may cause cellulitis. Patients have been admitted with severe cellulitis requiring intravenous antibiotics in hospital. Secondly, the patient is exposed to blood-borne pathogens, e.g. HBV, HCV and HIV, which are all known to be transmitted by needle stick

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injuries in drug abuse. More recently in London (UK) HBV has been transmitted by haemotherapy (the practice of injecting 'activated' blood under the skin or intramuscularly). These examples underscore the potential of spreading these infections, especially in KwaZulu/Natal, where they may be endemic. The official figures for HIV positivity in KwaZulu/Natal (regarded by many as an underestimate) are 27 per cent (May 1998); HBV is estimated as affecting 6.5–14 per cent of the population. This population of immuno-suppressed patients is also likely to be significantly more susceptible to both bacterial and viral infections.

CURRENT PRACTICE: THE COMPOSITION OF THE *MUTHIS*

The information on the current uses of *umgcabo* and *ukutshobha* described above was derived from interviews with three traditional healers working independently in different locations in KwaZulu: Mr Elliot Ndlovu from Kamberg, Mr Uzikayise Mchunu from Keate's Drift and Mr Nhlanhla Zwane from Mangweni, Sundays River. One untrained practitioner from near Pomeroy, who had inherited his *ukutshobha* horn from his father, who had been an *inyanga* in his time, was also questioned. Their accounts tally closely. In addition a young woman aged 32 from Impendle, who had had *umgcabo* performed on her six or seven times between the ages of 6 and 21 years, was interviewed. Her account corroborated those of the healers, showing that much the same practices have established themselves over a wide area of KwaZulu.

Two samples of *muthi* were purchased from Mr Uzikayise Mchunu, one for *umgcabo* and one for *ukutshobha*. A horn complete with *muthi*, porcupine quills and bicycle spoke was purchased from the Pomeroy practitioner (illustrated in Jolles and Jolles, 1998). All had been used recently, either on the day of purchase, 28 April 1997, or the day before. They were deposited in the Department of Virology of the University of Natal Medical School in Durban. Their potential to transmit bacterial or viral infection, particularly in the immunocompromised, requires further study.[5] Here we will focus on their composition in terms of Zulu pharmacology.

According to Mr Mchunu the mixtures purchased from him contained the following ingredients. For *umgcabo*:

1. *Mamba* fat. 'The fat of the black mamba is used in conjunction with other ingredients for chasing away bad spirits including baboon spirits and other animal spirits, *tokoloshe*, death spirits and spooks that frighten children at night. The black mamba is the most poisonous snake. So when *umgcabo* is done it prevents any poisonous

[5] The samples were tested for HIV/HIV DNA and were found to be negative. It was not possible to carry out titrations or to test for HBV and HCV. We wish to express our particular thanks to Professor A. N. Smith and Dr D. York, both of the Virology Department of the University of Natal, Durban, for their assistance.

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thing from entering the person' (Elliot Ndlovu, personal communication, 5 September 1997).
2. *Ikwantshu*. 'A bush about 1.5 m high with thorns on its stem. It can give you a sort of electric shock when you touch any part of it. All parts of the plant are burnt to ash, which is ground and mixed with other *muthis* and fat. It is used with *umgcabo* and *ukutshobha* against strokes and to revive people unconscious through witchcraft' (Elliot Ndlovu, 5 September 1997).
3. *Unhlangothi*, *Protorhus longifolia*. 'Pulverised bark is injected to cure hemiplegic paralysis believed to be caused by witchcraft' (Hutchings *et al*., 1996: 179).
4. *Impundulu* (artificial bird used in witchcraft). 'The oil is available from a supplier in Johannesburg' (Uzikayise Mchunu). '*Impundulu* is made by witches and other people practising witchcraft. You can get the oil from them. They mix fats and other ingredients and it becomes the bird. When it dies it is rotten at the same time. It will make people sick, and, if the person is not strong, sometimes kill him. *Impundulu* fat is use for security, to stop other *impundulu* attacking a person' (Elliot Ndlovu, 5 September 1997).
5. *Inga*, vulture. 'The fat of the vulture is used against poisoning by witchcraft because it is a strong, clever and brave bird. It is the strongest bird, it is so strong that it eats everything, even poison' (Elliot Ndlovu, 5 September 1997).
6. *Umkhovu*, familiar of witch: mute dwarf zombie; corpse. 'Any part of a fresh corpse, burnt and ground up, will do. It makes people who are unconscious wake up quickly. It also stops zombies sent by witches' (Elliot Ndlovu, 5 September 1997).
7. *Tokoloshe* fat. 'It is used against other *tokoloshe*' (Elliot Ndlovu, 5 September 1997).

For *ukutshobha:*
1. *Amahlunga kangwane*. 'A medium sized, deciduous tree (like croton) with a red bark, that grows on the Natal north coast. The bark, burnt to ash and ground, is used against paralysis; *umgcabo* and *ukutshobha*' (Elliot Ndlovu, 5 September 1997).
2. *Ikhathazo*, *Alepidea amatymbica*. 'Mainly for colds, coughs and influenza; antihypertensive, antimicrobial, etc.' (Hutchings *et al*., 1996: 223). 'This is an *inthelezi* [protective medicine] to stop criminals and witchcraft, but you can put it into *ukutshobha* mixtures because it works in many ways, such as making people tired' (Elliot Ndlovu, 5 September 1997).
3. *Ifinyezi*, *imfinyezi*, millipede, *Sphaerotherium punctulatum*. 'This is a millipede that is luminous at night., Ground live, boiled and mixed with other herbs, it is drunk against bad luck. Dried, burnt and ground and put into *ukutshobha* mixtures, it adds light to the other *muthis* so that they must work' (Elliot Ndlovu, 5 September 1997).
4. *Imfezi* spitting cobra. 'The fat is good against lightning—to stop the lightning sent by witchcraft from killing you or destroying your hut.

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Because the spitting cobra can blind you, and so can lightning, spitting cobra fat can be used to counteract lightning' (Eliot Ndlovu, 5 September 1997).

5. *Umhlangwe, simocephalus capensis*. 'Large, dust-coloured, non-poisonous snake, with a prominent spine; considered a bad omen if it comes into a kraal' (Doke *et al*., 1990: 320). 'An *umHlangwe* is definitely known to be a snake of an *umthakathi* [witch]. It is not an ordinary snake, for it has no bowels, but is created by trickery and magic. It is able to enter any house even if the door is closed, and there it causes illness' (Krige, 1950: 324).
6. *Ufudu, Dioscorea sylvatica*. Main use for 'blood problems' (Hutchings *et al*., 1996: 58). 'Blood problems, pig lice brought on by witchcraft. The pig lice come from the blood. It is boiled and drunk, but for *ukutshobha* burnt and ground' (Elliot Ndlovu, 5 September 1997).
7. *Unukani, Ocotea bullata*, black stinkwood, laurel wood. 'It is the strongest substance; it is added to many *muthis* to hold the power of the other ingredients and make them work together. It is like the driver of a span of oxen' (Elliot Ndlovu, 5 September 1997). 'Roots are mixed with roots of *Secamone gerrardii* and *Pteroclastrus rostratus* and *umafumbuka* and the dried body of a large fruit bat. The ingredients are ground to a powder which is rubbed into incisions made along the infected area to treat spinal disease' (Hutchings *et al*., 1996: 106).
8. *Ihlulu lenhlwathi*, dried blood of the Natal python. 'Whenever you mix *muthis, Ihlulu lenhlwathi* must be there because the python is the snake of the ancestors. So this is necessary because the ancestors will make the *muthi* work' (Elliot Ndlovu, 5 September 1997).

INTERPRETATION OF THE *MUTHIS*

In the case of the *umgcabo* mixture most of the ingredients are designed to neutralise the effects of witchcraft according to the homoeopathic principle of Zulu medicine which states that the same agent that caused the harm must be applied to remove it. This accounts for the inclusion of *mamba, impundulu* and *umkhovu*, all of which are commonly used as familiars by *abathakathi*, witches and wizards (Krige, 1950: 312 ff.). The same applies to the much feared river spirit *utokoloshe*, the source of nightmares and other ills. Bryant already mentions 'the fat of the water-sprite in bottles' (1905: 19). Nowadays it is imported from Mozambique, where the people are said to have a special method of catching *tokoloshe*, and traded through Johannesburg. *Unhlangothi* has several uses, the main one being the injection of the pulverised bark to cure hemiplegic paralysis believed to be caused by witchcraft. The same bark is also reputed to be used to cause the condition and, as a constituent of *umgcabo-muthi*, to protect against it. It is also used as an emetic to relieve heartburn and bleeding from the stomach (Hutchings *et al*., 1996: 179). So the ingredients of the *umgcabo-muthi* are designed to give protection against a range of afflictions caused by witchcraft, either

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by neutralising the vector, the familiar that carries the spell to the victim, or by imparting immunity to the effects. The underlying theory seems to combine the principles of homeopathy with the symbolic properties of the ingredients.

The *muthi* used for *ukutshobha*, on the other hand, consists of a mixture of ingredients, most of which could be used separately to treat particular illnesses, whilst others have an enhancing effect (such as the spitting cobra fat and the python blood). Most of them derive their influence from symbolic associations. The majority are 'black' medicines, either because they are black in the first place or as a result of being burnt and ground. This means that they can be used to drive out the 'blackness', i.e. pollution, from the body.[6] It also implies that they will have lost most of any 'allopathic' properties they might have had. I think it is true to say that the *muthi* for *ukutshobha* is designed as a general remedy, a sort of cure-all. This is supported by Uzikayise Mchunu's statement that today's mixtures have more ingredients than those used formerly, because 'there are new diseases to be treated, like high blood pressure, etc.'. He himself 'started adding new ingredients around 1990' (interview, 28 April 1997).

When one compares the stated properties of the ingredients of the *muthis* with the use for which they are intended (as outlined above), it becomes clear that the two are carefully matched: the *umgcabo muthi* to impart immunity to the harmful machinations of witches and sorcerers, the *ukutshobha muthi* to treat a range of physical ailments.

MEDICAL PRACTICE AT THE BEGINNING OF THE TWENTIETH CENTURY

The above are the present-day applications as practised by the healers we interviewed. A somewhat different picture emerges when one considers the usage around the turn of the century as recorded in A. T. Bryant's *Zulu Medicine and Medicine-men* (1905), E. J. Krige's *The Social System of the Zulus* (1950: 331 ff.) and other contemporary sources such as the James Stuart Archive of Recorded Oral Evidence. At that time the emphasis lay almost entirely on curative treatment. Incisions were made around the affected part and medication was applied. It might take the form of blowing steam from an infusion on to it, or rubbing in counter-irritants such as finely ground croton bark or the ash of the leaves and stalks of *iBohlololo*, *Senecio speciosus* (Bryant, 1909: 47 f.). Conditions treated in this way included paralysis of the legs (*ibid.*: 15, 69), various chest complaints (*ibid.*: 47 f.), rheumatic swellings (*ibid.*: 67 f.) and even fractures: 'The dark coloured portion of the root [of *uMathunga*, *Cyrtanthus obliquus*] below the bulb was dried, pulverized, and rubbed into incisions made at the seat of the breakage'

[6] Ngubane (1977: 120): 'There is in addition another set of symbolic meanings that operate within the colour symbolism. This is related to the notion of heat and cold. Illness is associated with heat. Black (and red) medicines, which represent illness, are always heated: they may be boiled, burnt into cinders to form black powdery medicines, administered as smoke arising from burning them, or heated in a container into which people dip and then suck their fingers.

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(*ibid.*: 78). The point to note is that specific remedies, often derived from a single *muthi* plant, were used to manage specific conditions. Most of the remedies were not heat-treated, i.e. were not converted into 'black' medicines (Ngubane, 1977: 120), but were used for their inherent 'allopathic' properties. Mixtures were also used to treat particular ailments, but there was no such thing as a general medication that could be applied to a range of complaints. The remedies, most of them in the form of dry powders rather than oily suspensions, were prepared individually for each patient: there was no risk of transferring body fluids from one patient to another.

In conclusion: the main difference between the old and the new practices seems to be that the old practice applied specific treatments to specific diagnoses while the new practice uses mixtures of many traditional medicines applied fairly indiscriminately to a wide variety of patients and groups. It is for this reason that the new practice carries an increased risk of spreading infection. On a more general level, this suggests that there may have been greater demand for the treatment of those illnesses, such as injuries and the many opportunistic infections, that were not associated with spiritual or social disharmony but were said to have 'natural' causes (*umkhuhlane*) and less demand for those regarded as having spiritual causes such as witchcraft, which required treatment with 'black' medicines.

LEGISLATION AFFECTING DIVINERS AND HERBALISTS IN NATAL

In practice as in law a distinction was drawn between the diviner, who provided the diagnosis, and the healer who then selected and applied the remedies:

> The Zulu medicine-man is a personage totally distinct from the Zulu diviner or so-called witch-doctor. [. . .] Both are commonly called *i-nyanga*, though the medicine-man is sometimes distinguished as the *i-nyanga yokwelapha* (the doctor for curing), and the witch-doctor as the *i-nyanga yokubhula* (the doctor for divining). [Bryant, 1905: 13]

As early as 1891 it became an offence in Natal to practise as a 'male or female diviner'.[7] However, from 1910 the colonial administration

[7] Laws of Natal, No. 19 of 1891. This short piece of legislation contains the main principles of all subsequent legislation. (Compare also Law 24 of 1886 of the Cape of Good Hope.) It is perhaps worth quoting in full:

'268. Whoever shall practise as an *Inyanga yo ku bula* or *Isanusi* (male or female diviner), or as a rain doctor, or as a lightning doctor, shall be deemed guilty of an offence.

'269. Whoever by himself, or by an agent or messenger, consults or employs a male or female diviner, or a rain or lightning doctor, as such, shall be deemed guilty of an offence, and the agent or messenger so employed shall also be deemed guilty of an offence.

'270. Any person professing for gain a knowledge of witchcraft or the use of spells or charms, or who shall advise any person applying to him to bewitch or injure persons or property, or who shall supply any person with the pretended means of witchcraft, shall be deemed guilty of an offence.'

For clarification of the terms 'witch' and 'sorcerer' see Milton and Cowling (1988: (E2 1–5).

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recognised medicine men (i.e. the 'doctors for curing') by granting them licences to deal in medicinal herbs and roots and to practise 'among their own people' (Gumede, 1990: 91). At the time this was an important measure of recognition. It was opposed by mission doctors, including Dr James B. McCord, founder of the McCord Zulu Hospital in Durban:

> Granting such a license is in my opinion a grave mistake, since it gives quasi-legal sanction to the drug dispenser without requiring from him any knowledge of drugs or training in their preparation. Moreover, a true Zulu herbalist doesn't exist outside the pages of fiction. [McCord and Douglas, n.d.: 95]

This view may have been understandable, as many patients whose treatment by their local *inyanga* had failed went on to present at Dr McCord's clinic. But it did show lack of appreciation of the very real knowledge of the pharmaceutical properties of medicinal plants possessed by many herbalists. Bryant, with whose work McCord must have been familiar, estimated that 'a good average native doctor' would have been acquainted with some 240 medicinal plants out of a total of about 700 known to occur in the field (Bryant, 1905: 84).

Legislation concerning herbalists and diviners was a two-pronged affair. For the colonial law maker herbalists were associated with practitioners of non-academic medicine such as homeopaths, naturopaths and osteopaths (Act 52 of 1974). They were all the more easily accepted as they had European counterparts. The Zulu diviner had no ready equivalent in post-Enlightenment European society. As a result the African perception of a fundamental distinction between diviner (*isangoma*) and witch (*umthakathi*) was not reflected in the legislation.[8] From the outset colonial legislation tore asunder the two integral and interdependent branches of Zulu medicine: the diagnostic/divinatory and the curative.[9] The root of the problem lay in the failure of the legislators at the turn of the century to grant recognition to the very different interpretations of the aetiology of disease in Western and in Zulu medical theory. The epoch-making advances in biomedicine, particularly bacteriology, in the second half of the nineteenth century had tilted Western perceptions entirely towards material causation, whereas in Zulu understanding many illnesses were attributed to spiritual causes such as witchcraft and the displeasure of the ancestors. Within this context the skills of the diviner were regarded as indispensable:

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[8] Compare on this point Ralushai *et al.* (1996: 61): 'In the majority of the countries south of the Sahara, the practice of magic and witchcraft is now prohibited by a variety of laws, which are not readily appreciated by people, of whom a large number regard the operation of magic as normal events of everyday life. In this case, part at least of the trouble arises from the failure of most of the legislation to draw a clear line between the so-called witch, the sorcerer, and the witchfinder.'

[9] Bryant (1966: 84) points out that the two professions 'do still considerably overlap', and that the witch doctor possesses 'an extensive acquaintance with disease and curative herbs, though his office is rather to indicate than to administer'. However, that does not blur the distinction between them. Compare the deferential manner of approaching a diviner with the everyday manner of addressing herbalists reported by Krige (1950: 298 ff.).

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> The doctor [i.e. diviner] is, however, more than a link between the spirits and their descendants: he is the protector of society. He it is who can smell out the evil men who have acquired power to work evil on their neighbours and bring disaster on the community. Hence the doctor is one of the pivots upon which the welfare of society rests and he is for this reason most highly respected. [Krige, 1950: 297 f.]

Diviners represented a source of authority independent of the colonial administration. In times of social stress they could assume a political function. One of Shaka's first acts on coming to power (1816) had been to break the influence of the diviners (Ritter, 1955: 90–104; Webb and Wright, 1976: I, 9). The colonial government followed suit by imposing legal sanctions. Thus in the Cape 'the onslaught against "witch-doctors" resulted from their feared political role in the frontier wars'.[10] The Cape legislation extended to Rhodesia, where it fulfilled a similar function. There were no comparable circumstances in Natal at the time the Natal legislation was enacted (1891). However, in the course of the struggle for supremacy between the African National Congress and the Inkatha Freedom Party in the period leading up to the 1994 election diviners were once again targeted. Although they operated primarily through the medium of the spirit, diviners exercised control over the bodily substance of their clients: they restored somatic integrity by reinstating the spiritual and social equilibrium,—society being a continuum of the living and the dead. As such, they also re-established the claims of society upon the individual. In times of conflict this could become politically significant. In the nineteenth century it ran counter to the interests of the colonial administration trying to extend the area under its control and integrate its subjects into an economy in need of labour. A hundred years later it stood in the way of a centralised political party trying to enhance its presence in rural areas where it had doubtful support.

In Natal diviners (*izangoma*) had been explicitly prohibited from practising for gain as early as 1891 (section 268 of law 19 of 1891, [Natal] Natal Code of Native Law). This was reinforced by case law and further legislation[11] and finally subsumed (along with other colonial statutes) in the Witchcraft Suppression Act No. 3 of 1957 as amended by the Witchcraft Suppression Amendment Act No. 50 of 1970, which remains in force to the present day. The Act is aimed at six categories of persons:

1. Any person who names or indicates another person as being a wizard or witch is guilty of an offence.
2. Any person who names or indicates any other person as being a witch or wizard and is proved at his trial to be by habit and repute a 'witch-doctor' or witch finder faces a heavy sentence.

[10] I am indebted to an anonymous referee for this intimation.

[11] In Madebena *v.* Rex of 8 December 1911 a diviner was sentenced to six months' imprisonment with hard labour for accepting a fee of £2 for medical services rendered (Gumede, 1990: 92).

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3. Any person who employs someone to advise him or any other person how, by means of witchcraft, a wrongdoer may be identified, commits an offence.
4. Any person claiming to have knowledge of witchcraft or of the use of charms. It is an offence to advise someone how to bewitch any person or animal or to supply someone with the means of witchcraft.
5. Those people who attempt to practise witchcraft.
6. Those people who, for gain, claim to possess skills to divine.

(Abbreviated from Ralushai *et al.*, 1996: 54.) All these categories affect diviners, but the final one seems to be formulated specifically with them in mind. The text itself (para. 1 f and 1iv) reads as follows:

> Any person who [. . .] For gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration or undertakes to tell fortunes, or pretends from his skill in or knowledge of any occult science to discover where and in what manner anything supposed to have been stolen or lost may be found, shall be guilty of an offence and liable on conviction [. . .] to a fine not exceeding two hundred rand or to imprisonment for a period not exceeding two years.

The prime purpose of the legislation was undoubtedly to outlaw witch finding and curb the murders associated with it. As Bawa Yamba (1997) has pointed out, witch finding could be a very profitable pursuit. Making it illegal to practise 'for gain' was intended to undercut the commercial incentive. The traditional courts (which administer justice according to customary law) regarded this Act as 'a very unjust piece of legislation, because its aim is not to punish witches but those individuals who name others as witches' (Ralushai *et al.*, 1996: 54). This view found support among the people: Berglund (1976: 276) quotes one of his informants as saying, 'But in the time of Shaka many witches were killed. The trouble today is that they are not killed. So they become very old and clever.' Coincidentally the Act also affected those diviners involved with medical diagnosis. Although it may not have been invoked against them very frequently, it placed them under constant threat and opened the door to prosecution whenever the prospect of competition between diviners and other medical practitioners (for instance, licensed herbalists, *izinyanga*) arose. In fact it was used by the herbalists to promote their interests. In 1931 they formed their own professional body, the Natal Native Medical Association, in which they deliberately 'defined themselves in contradistinction to the *isangoma* or "witch-doctor" who "merely relies on superstitions of the Native race and on love-philtres for his remedies"' (Mafavuke Ngcobo, Secretary of the Natal Native Medical Association, to the Minister of Native Affairs, Cape Town, 2 March 1931, quoted in Flint, 1998, 14).

The current legislation setting out the conditions under which herbalists are allowed to practise is contained in the KwaZulu Act on the Code of Zulu Law, No. 6 of 1981; it is based on previous legislation going back to 1910. The first paragraph lays down that only licensed black medicine men, herbalists and midwives may practise for gain (para. 87(1)):

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> Black medicine men, herbalists and midwives are known as *Izinyanga zokwelapha* (those skilled in healing), *Izinyanga zemithi* (herbalists) and *Umbelethisi* (midwife) respectively and any Black may practise for gain if duly licensed but not otherwise.

The remainder of the Act sets out the conditions under which a licence could be issued and the rights to which the licensee was entitled. It also regulated the nature of the permitted medicinal substances and how they were to be traded. M. V. Gumede, a black doctor and district surgeon, regarded the Act of 1981 as 'an attempt to bring traditional healers "within the fold", that is, a code of conduct that a reasonable man would find acceptable' (1990: 95). However, by omission the Act of 1981 still upholds the previous legislation's discrimination against all forms of divination, including medical diagnosis. The overall effect was to shift the emphasis away from the rights and wrongs of divination to the economic advantages to be gained by practising it.

CONSEQUENCES OF THE LEGISLATION

In the early twentieth century payment for all medical services were in kind. For a healer the norm was an ox or a cow, paid on completion of the cure. 'Custom also allowed the *inyanga* to say, *Ngesuleni izinyembezi!* (Wipe my tears from my eyes). The relatives understood that one beast was not enough' (Gumede, 1990: 90 f.; also Krige, 1950: 298 f.). For the services of an 'ordinary diviner' the lowest fee was 'the equivalent of one fowl' (Ritter, 1955: 367). But, with the increasing penetration of the money-based economy, payment in kind was replaced by cash. This was particularly true of the period from the 1950s onwards, when the South African economy entered a phase of rapid expansion which swelled the migrant labour pool. In 1997 treatment by an *inyanga* could cost in excess of R1,000 (rather less than the price of a cow), whilst the diviner (*isangoma*) was still legally prohibited from accepting any remuneration. In so far as the intention of the legislation was to discourage divination, it has certainly failed: far from marginalising the activities of the diviners, it has contributed to the creation of a new class of diviner-healers by forcing them to register as herbalists. The consequences were clearly evident in the 1960s when Berglund undertook his research. Citing his Zulu informants and other sources, he noted that the number of diviners had increased greatly, and that two distinct classes had emerged: conservative diviners and popular ones. Of the latter he says (1976: 188):

> Popular diviners abound everywhere, their advice being sought frequently but not infrequently disregarded. These sometimes go out of their way to seek inquirers, hoping to make a reasonably successful case for people who accept their services. Quite often popular diviners have either not completed their time of training with an experienced diviner or have been schooled by an incompetent tutor. Conservative diviners resent these trends very strongly.

There had always been a tendency for the diviner to encroach upon the

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territory of the herbalist. It soon became apparent that it was more profitable to practise in both capacities rather than as a herbalist or diviner alone. Berglund continues: 'Few diviners remain only diviners. A great majority also practise medicine, thereby combining divination with medical attention. This is also true of conservative diviners' (1976: 188). It remains the case today. The pure herbalist dealing with common 'natural' diseases (*imkhuhlane*) is increasingly exposed to competition from state-subsidised health services, whereas the services of the diviner cannot be duplicated by the state (interview with Nhlanhla Zwane of Mangweni, 29 April 1997). According to Elliot Ndlovu, himself a diviner and healer, most of the new generation of diviner-healers do not undergo the rigorous training formerly demanded of the herbalist. Many have no first-hand knowledge of the plants they prescribe. They cannot recognise them in the wild, so they have to purchase them in dried form from pharmacies or in markets. When they are inaccurately labelled, as sometimes occurs, the new healers are unable to tell the difference and administer the wrong remedies. This can cause a lot of harm (interview, 6 February 1997).

The following examples illustrate the effects of the economic pressures outlined above on the careers of three of today's healers. All of them straddle the divide between *isangoma* and *inyanga*.

Uzikayise Mchunu of Keate's Drift, Msinga, is a healer of considerable reputation who attracts patients from as far afield as Johannesburg—a journey of some five or six hours by bus. He was born in Muden in 1943. He started training as an *inyanga* and learnt how to mix herbal medicines. However, he did not earn enough money. He found a job in Germiston where he converted to the Zionist Church and became a prophet, *uphorafiti*, i.e. a spiritual healer. He started work as a prophet in 1961 or 1962 but subsequently moved to Mtubatuba, where he took up training as a diviner, *isangoma*. His training lasted four months. He set up his practice as healer in Keate's Drift in 1968. As far as I am aware he and his family live entirely from the proceeds of his practice.

Elliot Ndlovu of Kamberg was born in 1962. He is much respected as a diviner and prophet. He is also a herbalist of local and international repute, having exhibited his remedies at the Exhibition Centre in Durban and at the Chelsea Flower Show (1997). He is involved in training novices, *amathwasa*, and is seeking to extend his economic base by running a training centre for apprentices at his home in Kamberg. He operates a nursery for medicinal plants (Prins, 1996) and is planning to open an arts and crafts shop. He is interested in attracting non-Zulus and foreign tourists with a view to creating a better understanding of Zulu culture.

Nhlanhla Zwane, also in his 30s, lives in a populous homestead (of which he is not the head) in a fairly remote country district. He practises divination and healing in both the Christian and the heathen traditions, according to the requirements of his clients. He has a well organised and very well stocked 'dispensary'. Yet, because the area is relatively sparsely populated and has access to a clinic, he is unable to

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live on the proceeds of his practice. So he puts in two days a week as healer, working at a job the rest of the time.

So the first consequence of the legislation seeking to regulate traditional medical provision was to undermine and ultimately abolish the old distinction between the *inyanga yokubhula*, *isangoma*, the diviner, who was responsible for establishing the spiritual cause of the illness, and the *inyanga yokwelapha*, the healer. In so far as this system had provided its own checks and balances in pre-colonial Zulu society the changes brought about destabilisation. The diviner was criminalised (but not effectively suppressed) and a new type of practitioner created who offered the services of both. A comparison between medical practice at the turn of the century and the present approach points to a further important consequence: therapeutic techniques that had formerly been the province of the healer were adapted to the purposes of the diviner. In particular, the incisions and punctures that had been used locally to treat specific disorders were now applied to the whole body as a general protection. Berglund commented on the growing number of diviners in the 1960s. Van Nieuwenhuijsen (1968) also reported a strong and continuing increase. He attributed it to the 'breaking up of traditional Zulu life patterns due to urbanization and a subsequent increase in the number of neurotic personalities among Zulu in general' (Berglund, 1976: 188). This reflected the strong demand for migrant labour in the 1960s with its attendant disruption: pass laws, overcrowded hostels in the cities, dual families and a countryside denuded of men. The violence and insecurity, particularly in KwaZulu-Natal, that accompanied the political transition in South Africa from the late 1980s onwards greatly exacerbated this trend by creating a widespread demand for protective and supportive expedients against witchcraft and crime.[12] That, in turn, led to a further rapid increase in the number of diviner-healers, but at the cost of standards of training and proficiency, and (a recurring theme) widely imputed malpractice. It also attracted diviners from Lesotho, hoping to profit from the situation. As the distinction between diviner and herbalist never existed in Sotho traditional medicine, the influx of Sotho diviners underpinned the position of the diviner-healers. So it is not without irony that legislation initiated with the intention of curbing those aspects of traditional medicine that were most at variance with Western concepts ended up opening the floodgates to many of the practices it was intended to suppress.

[12] The increase of witchcraft in times of strife and disruption is well attested for other parts of Africa; cf. Booth (1983: 75–6), Debrunner (1959: 62, 92), Evans (1993), Evans and Singh (1991: 46–8), Fardiman (1993), Kohnert (1996: 1 f.), Schönhuth (1992: 126–8). Debrunner reports that in Ghana a black powder was injected or rubbed into a cut in the skin 'to make your blood bitter so that no witch cares to taste it'. He further notes that 'in the past—before 1850—the witches were comparatively few, and no major danger to society' (1959: 62). 'It is indeed striking . . . that just after the final establishment of the *pax britannica* in Ghana in the first years of the century, the first great wave of witchcraft fear and anti-witchcraft shrines was sweeping over the country' (*ibid.*: 65).

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TRADITIONAL MEDICINE IN CONTEXT

The problems arising out of the coexistence of two theoretically opposed and largely incompatible systems of medicine in South Africa could be glossed over so long as the institutions of the state were based on the principle of 'separate development'. This was the case in the period 1948–94. As a result, an estimated 80 per cent of the black population continued to turn to traditional healers in the first instance, and still do so now. The emphasis of the new administration on the provision of primary health care through the creation of a network of rural clinics is bound to affect this situation in the long run. At the very least, it will catalyse renewed interaction between the two systems. Faced with limited resources and severe staffing problems, the administration will have to opt for a co-operative approach to traditional healers. Both sides are reconsidering their position. Traditional healers are turning to clinics and hospitals as an extension of their practices, though they are often disappointed by the lack of feedback on their patients (interview with Nhlanhla Zwane of Mangweni, 29 April 1997). Western-trained researchers are evaluating the effectiveness of traditional remedies in terms of improvement in the quality of life, for instance, of patients suffering from AIDS (personal communication, Professor A. N. Smith, University of Natal Medical School, Durban).[13] Efforts are also being made to reverse the

[13] This is a topic that requires further study. Most attention has centred on the traditional hospitals that have sprung up in Durban. The first to open was the Sunshine Traditional Hospital in November 1996. By February 1998 there were six which were regularly inspected by the Durban City Health Department. They practised all forms of traditional healing, including *umngcaba* and *ukutshobha*. The Sunshine's managing director, Petros Gwala, commented, 'Sometimes they don't understand when a patient comes for treatment; maybe we *ugcaba* [cut] them. So we explain why we sometimes have to cut our patients' (*Mail and Guardian*, 20–6 February 1998). 'Dr' Queen Ntuli, 39, who was 'a sangoma and superintendent of the Freedom Traditional Hospital' on Gale Street, and who 'graduated' at the first official graduation ceremony of traditional healers, held at the Mangosuthu Technikon, Durban, under the auspices of the Department of Community Outreach (Director Ms Jan Beeton) in September 1998 (*Daily News*, 4 September 1998), also defended the techniques of *umngcaba* and *ukutshobha* (*Sunday Times KZN*), 9 February 1997): 'We use what we call African acupuncture needles which are porcupine spikes to massage muscles and to release pain from the patient's body. Muti is also placed under the skin, but only if it is needed. We don't cut unnecessarily.' The hospital has since 'been closed because of a lack of hygiene' (*Mail and Guardian*, 20–6 February 1998). It treated patients from all over South Africa for a wide range of diseases, including 'those who have suffered strokes, those with cancer, high blood pressure, TB, arthritis and family problems'. None of the healers interviewed claimed that they could cure AIDS, but they maintained they could relieve symptoms such as diarrhoea and vomiting. Thus Queen Ntuli attested, 'I warn all our HIV patients that as sangomas we do not have a miracle cure for AIDS,' and Judas Milazi, 'who operates a hospital with nine nurses, eight wards and a dispensary stocked with herbs and traditional muti' in the Berea, a residential district not far from the university, contended, 'But we do have herbs that can keep an AIDS patient alive longer than anticipated.' Elliot Ndlovu (interview, 20 April 1999) agreed that only palliative treatment for AIDS was possible. He repeated that the urban healers had little first-hand knowledge of *muthi* plants. They were in it merely for the money. He thought that the rampant spread of disease could be halted only by a return to the old ways.

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concomitants of colonialism by restoring diviners to their previous status. The report of the Commission of Inquiry into Witchcraft Violence and Ritual Murders in the Northern Province of the Republic of South Africa (Ralushai *et al.*, 1996) contains proposals for a 'Traditional Medical Practitioners' Council' (more recently: 'National Traditional Medical Council') along the lines of the one established in Zimbabwe, a 'National Traditional Healers' Association' and a new category of licensed healer: the 'Registered Spirit Medium' (64 ff., 80). However, a more recent report prepared jointly by the National Council of Provinces' sub-committee on social services and the National Assembly's health portfolio committee suggests that the registered categories should include herbalists (*izinyanga*), diviners (*izangoma*), midwives (*ababelekisi*) and surgeons/circumcisors (*izangoma*), midwives (*ababelekisi*) and surgeons/circumcisors (*izingcibi*) 'but exclude *abathandazi* (spiritual healers) because their accreditation is still unclear' (*Natal Witness*, 5 August 1998, p. 5).

Such official endeavours are likely to be of marginal significance, because the principles informing the current administration are based on the same European post-Enlightenment values that were responsible for the original legislation against diviners in the nineteenth century, in this case 'the extension of "rational" control over domains of nature that were vital and dangerous', as Comaroff and Comaroff so aptly put it (1992: 232). Yet those values are not shared by the majority of the population. In their experience, life remains uncertain and dominated by irrational forces which need to be appeased and/or manipulated as a matter of survival. The conflict of *Weltanschauungen* inherent in these two systems has been a familiar tenet of European thought since the revolt of the Romantics against the philosophy of the Age of Reason at the end of the eighteenth century. It forms the substratum of nineteenth-century positivism as reflected in literature from Goethe onwards and has made its impact on twentieth-century science. In Europe it was largely a philosophical discourse carried by the rising middle classes and expressing their experience. In post-colonial Africa it has become a social discourse between the newly privileged classes and the underprivileged against a background of widening inequalities. Health care is situated at the centre of this discourse, at the intersection of political, social and economic interests.

Returning to the question of the control of infection, it seems improbable that any measures taken at this late stage, such as the legal rehabilitation of diviners, will be able to restore the integrity of Zulu medicine with its bi-polar structure. The social and economic pressures outlined above, and the attendant instability, will continue to enhance the position of the diviner, often at the expense of the herbalist, whose primary health-care functions are being taken over by the state. Under these circumstances it would appear futile to attempt to proscribe such basic techniques as *umgcabo* and *ukutshobha*. There may be a place for the inclusion of simple agents with activity against enveloped viruses and bacteria in the *muthis*—such as detergents which break up the lipid envelope of the viruses and chlorhexidine as an antibacterial. This was

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found to be acceptable to the diviners whom we questioned. Moreover, there are precedents for such transfers between traditional and Western remedies, the widespread use of Jeyes' Fluid as a protective agent against witchcraft (*intelezi*) being a case in point. HBV can be controlled by immunisation, preferably general immunisation at an early age. This is under consideration in some Asian and European countries (for instance, Germany, with an estimated infection rate about 0·6 per cent). However, the experience with yellow fever, which remained rife despite the introduction of a vaccine in the 1940s, suggests that it would be difficult to put into practice under African conditions. HBV immunisation involves three injections at specific intervals, whilst yellow fever only requires one (cf. Turner, 1999: 6). The proposed statutory National Traditional Medical Council will also need to consider what prior training in aseptic technique it will require of those traditional healers who wish to be registered.

Today's diviners operate in a very different environment from that of their colleagues at the beginning of the century. Rectifying some of the consequences of colonial and post-colonial legislation will address only a part of the greater problem of redefining traditional medicine in the context of modern health delivery. Other legislations have had to grapple with similar problems in accommodating 'alternative' medical procedures, many of which are of unproven therapeutic value. South African legislators should this time strive to set economic incentives in such a way as to protect the long-term interests of the historically disadvantaged patients.

REFERENCES

Auslander, M. 1993. '"Open the wombs!": the symbolic politics of modern Ngoni witchfinding', in J. and J. Comaroff (eds), *Modernity and its Malcontents: ritual and power in postcolonial Africa*, pp. 167–92. Chicago and London: University of Chicago Press.

Berglund, A-I. 1976. *Zulu Thought Patterns and Symbolism*. London: Hurst; Cape Town and Johannesburg: David Philip.

Bisseker, C. 1997. 'AIDS costs multiply: study', *Financial Mail*, 25 July, pp. 40–1.

Booth, A. R. 1983. *Swaziland: tradition and change in a southern African kingdom*. Boulder CO: Westview Press.

Bryant, A. T. 1905. *Zulu–English Dictionary*. Maritzburg: Davies.

——1966. *Zulu Medicine and Medicine-men*. Cape Town: Struik. Originally in the *Annals of the Natal Government Museum*, 1909.

Caldwell, J. C., and Caldwell, P. 1994. 'The neglect of an epidemiological explanation for the distribution of HIV/AIDS in sub-Saharan Africa: exploring the male circumcision hypothesis', in *Prevention in the Developing World: demographic and social science perspectives*, supplement to *Health Transition Review* 4. Canberra ACT: Australian National University.

Comaroff, J., and Comaroff, J. 1992. *Ethnography and the Historical Imagination*. Boulder CO, San Francisco and Oxford: Westview Press.

Comaroff, J., and Comaroff, J. (eds). 1993. *Modernity and its Malcontents: ritual and power in postcolonial Africa*. Chicago and London: University of Chicago Press.

https://doi.org/10.3366/afr.2000.70.2.229 Published online by Cambridge University Press

Debrunner, H. W. 1959. *Witchcraft in Ghana: a study on the belief in destructive witches and its effect on the Akan tribes*. Kumasi: Presbyterian Book Depot.
Doke, C. M., Malcolm, D. M., Sikakana, J. M. A., and Vilakazi, B. W. 1990. *English–Zulu, Zulu–English Dictionary*. Johannesburg: Witwatersrand University Press.
Evans, J. 1993. '"Where can we get a beast without hair?" Medicine murder in Swaziland from 1970–1988', *African Studies* 52 (1), 27–42.
Evans, J., and Singh, P. 1991. 'Muti murders: ritual responses to stress', *Indicator SA* 8 (4), 46–8.
Fardiman, J. A. 1993. *When we began there were Witchmen: an oral history from Mount Kenya*. Berkeley CA, Los Angeles and London: University of California Press.
Forsen, A. B. van. 1985. 'Ritual Murder, Polity and Identity in Swaziland'. Paper presented at the eightieth Congress of the International Association for the History of Religion, Sydney.
Flint, K. 1998. 'Diagnosing their Ills: competition between African healers and European medical practitioners in KwaZulu-Natal in the 1920s and '30s'. Paper given at the History Department of the University of Natal, Pietermaritzburg, 2 September.
Gumede, M. V. 1990. *Traditional Healers: a medical practitioner's perspective*. Cape Town and Johannesburg: Blackshaw.
Hibberd, P. L. 1995. 'Patients, needles and healthcare workers: understanding the epidemiology, pathophysiology and transmission of the human immunodeficiency virus, hepatitis B and C and cytomegalovirus', *Journal of Intravenous Nursing* 18 (6 suppl.), S22–31.
Hutchings, A., Scott, A. H., Lewis, G. and Cunningham, A. B. 1996. *Zulu Medicinal Plants: an inventory*. Pietermaritzburg: University of Natal Press.
Janzen, J. M. 1992. *Ngoma: discourses of healing in Central and Southern Africa*. Berkeley CA, Los Angeles and Oxford: University of California Press.
Jolles, S., and Jolles, F. 1998. 'African traditional medicine: potential route for viral transmission?' *Lancet* 352 (4 July 1998), 71.
Katz, S. H. 1989. 'Uvulectomy: a common ethnosurgical procedure in Africa', *Medical Anthropology Quarterly* 3 (1), 62–9.
Kohnert, D. 1996. 'Magic and witchcraft: implications for democratization and poverty-alleviating aid in Africa', *World Development* 24, 1347–55.
Krige, E. J. 1950. *The Social System of the Zulus*. Reprinted Pietermaritzburg: Shuter and Shooter, 1988.
Last, M., and Chavunduka, G. L. (eds). 1986. *The Professionalisation of African Medicine*, International African Seminars, New Series, No. 1, Manchester: Manchester University Press for the International African Institute.
Mander, M., Mander, J., Crouch, N., McKean, S., and Nichols, G. 1995. *Catchment Action: growing and knowing Muthi plants*. Howick: Share-Net.
McCord, J. B., and Douglas, J. S. N.d. *My Patients were Zulu*. New York and Toronto: Reinhart.
Milton, J. R. C., and Cowling, M. G. 1988. *South African Criminal Procedure* III, *Statutory Offences*, second edition. Cape Town: Juta.
Ngubane, H. 1977. *Body and Mind in Zulu Medicine: ethnography of health and disease in Nyuswa-Zulu thought and practice*. London, New York and San Francisco: Academic Press.
——1986. 'The predicament of the sinister healer', in M. Last and G. L. Chavunduka (eds). 1986. *The Professionalisation of African Medicine*. International African Seminars, New Series, No. 1, Manchester: Manchester University Press for the International African Institute.

https://doi.org/10.3366/afr.2000.70.2.229 Published online by Cambridge University Press

Nieuwenhuijsen, J. W. van. 1968. 'The witchdoctor institution in a Zulu tribe', *Santa News* [Johannesburg] 7 (3), 4–5.
Prins, F. E. 1996. 'Prohibitions and pollution at a medicinal plant nursery: customary implications associated with ethnobotanical reserves in conservative areas of KwaZulu-Natal', *Natal Museum Journal of the Humanities* 8, 81–93.
Ralushai, N. V. *et al.* [1996]. *Report of the Commission of Inquiry into Witchcraft Violence and Ritual Murders in the Northern Province of the Republic of South Africa*. [Pietersburg.]
Ritter, E. A, 1955. *Shaka Zulu: the rise of the Zulu empire*. London: Allen Lane.
Schönhuth, M. 1992. *Des Einsetzen der Nacht in die Rechte des Tages*. Ethnologische Studien 20, Münster: Lit Verlag.
Turner, M. 1999. 'Hunt for homespun remedy to wipe out the malaria mosquito', *Financial Times*, 21 May.
Webb, C. de B., and Wright, J. B. (eds). 1976. *The James Stuart Archive of Recorded Oral Evidence relating to the History of the Zulu and Neighbouring Peoples*. Pietermaritzburg and Durban: University of Natal Press.
Yamba, B. 1997. 'Cosmology in turmoil: witchfinding and AIDS in Chiawa, Zambia', *Africa* 67 (2), 200–23.
Zavriew, L. 1994. 'Dangerous practices', *West Africa*, 9–15 May, p. 815.

ABSTRACT

This article arose out of an attempt to quantify the risk of transmitting blood-borne diseases, in particular Hepatitis B and HIV, through the practice of making incisions (*umgcabo*) and punctures (*ukutshobha*) in the skin for the purpose of introducing medication (*muthi*) into the human body. The intention was to examine means of containing the risk. It soon became apparent that the practice of these therapies was inextricably bound up with legal and economic issues arising out of the impact of colonialism on Zulu medicine. Any endeavour to contain them would first have to address these fundamental issues. The article takes a step in that direction by (1) examining in detail some of the practices of diviners and herbalists in their historical context and (2) showing how colonial and post-colonial legislation has affected traditional healers and their clients in rural KwaZulu/Natal.

RÉSUMÉ

Cet article provient d'une tentative de quantification de risque de transmission des maladies par voie sanguine, en particulier l'hépatite B et le virus HIV, dans le cadre de la pratique qui consiste à faire des incisions (*umgcabo*) et des ponctions (*ukutshobha*) intradermiques dans le but d'introduire un médicament (*muthi*) dans le corps humain. L'intention était d'examiner des moyens de limiter ce risque. Il est vite devenu évident que ce pratiques thérapeutiques étaient inextricablement liées à des problèmes juridiques et économiques de l'impact du colonialisme sur la médecine zouloue. Toute tentative de limiter ces risques doit d'abord aborder ces problèmes fondamentaux. L'article fait un pas dans cette direction en examinant en détail certaines practiques utilisées par les divinateurs et les herborists, dans leur contexte historique, puis en montrant l'incidence de la législation coloniale et postcoloniale sur les guérisseurs traditionnels et leurs clients dans la région rurale du Kwazulu-Natal.

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