Traditional rituals and plural medical systems in a pandemic

At the time of writing, the numbers of COVID-19 cases and related deaths have been drastically on the rise in the Eastern Cape province of South Africa, despite the province initially having one of the lowest caseloads. As reported by the Eastern Cape Department of Health, 200 COVID-19 cases in the Eastern Cape are linked to just three funerals in the province. These cases are reportedly attributed to families not adhering to state-sanctioned limits of 50 people or fewer at funerals. The virus is understood to have proliferated as a result of various traditional practices at funerals, including the sharing of food, water and tools for manually digging the gravesite. Public commentary has largely scorned this conduct, and the people attending these funerals have been treated as irrational and without logic or comprehension of the challenges posed by COVID-19. In this article, we want to complicate these understandings by contributing some meaning and context to this conduct of many in the Eastern Cape, and the arguably the larger South African context.

Africans contexts, unlike much of the Western world, present numerous challenges in relation to biomedically and epidemiologically centered official interventions and responses against the spread of COVID-19. African social scientists, especially anthropologists and sociologists, have long raised issues with biomedical approaches that make little effort to understand why people lack trust and confidence in the state biomedical health systems. One of the prevailing questions is why people behave the way they do (for example by continuing to hold gatherings through the practice of traditional rituals, burials and other ceremonies), despite widespread biomedical interventions that tell them to behave otherwise (e.g. to practice social and physical distancing to curb the spread of COVID-19).

There are two central reasons why people often choose to ignore, or to not participate in, critical biomedical operations key to perceived curbing of infections. These issues are, firstly, a general widespread distrust of the state and political power in the general populace. Secondly, there is a historically rooted distrust of biomedical systems rooted in the West.

Context must be considered
Speaking recently to CBS Miami, infectious diseases expert Professor Aileen Marty of the Herbert Wertheim College of Medicine at Florida International University observed that COVID-19 is most easily transmitted in spaces where people are up close and personal, as observable in many urban contexts across the world.

The responses to COVID-19 have largely followed a biomedical public health-informed approach that includes social and physical distancing, various forms of hygiene practices and treatments in the case of transmission of the virus.

What has largely been missing in these discourses of COVID-19 responses and approaches is narratives and experiences from contexts where the biomedical system is not the only hegemonic form of healthcare. South Africa is one such context.

While biomedicine enjoys hegemony in South Africa, we have a medically plural society where people do not only consult biomedical services, but various other avenues of healing. This most commonly includes the important healing roles played by traditional healers (izangoma) and herbalists (iinyanga).

Mistrust rooted in past abuses
South Africa has a very complicated relationship with western biomedical systems. These complications stem from the existing historical knowledge of the implications of healthcare workers in collaborating with the apartheid government. As the Truth and Reconciliation Commission Reports showed, the medical system under apartheid was used nefariously to break Black people. This included psychiatrists giving Black prisoners medication that would weaken them, making it easy for prison wardens and the police to torture them during detention. Psychologists were tasked to identify the weaknesses of prisoners, their breaking points and vulnerabilities of hundreds of prisoners.

Under apartheid South Africa, healthcare workers were responsible for the breaking of Black people in varying levels. This did not solely affect political prisoners; it also affected their families and communities.

It is not surprising, then, that there has been some distrust and scepticism from some sections of the Black population in South Africa about COVID-19. In parts of public memory, healthcare workers
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continue to work towards Black people’s deaths, rather than their treatment and healing of medical conditions.

In the post-apartheid context, we have seen forms of replication of arguably apartheid-based research such as the controversial study conducted at Stellenbosch University in South Africa in 2019 which concluded that “Coloured” women stand the risk of having a much lower intelligence because they have low levels of education and risky behaviours. This research has been taken down from research journals for being both racist, eugenicist and intellectually racist.

How Ebola was halted

Furthermore, part of the tensions lies in so many biomedical approaches often doing away with, or delaying various other forms of traditional practices. Marty reminds us that the huge Ebola outbreak in West Africa was ended without an anti-viral or vaccine.

What is often not in the public domain, but was central to halting the spread of Ebola in West Africa, was the role of social scientists, especially medical anthropologists. Like many African contexts, West African contexts have various traditional practices where touch, physical embracing and close human contact is central to social well-being and the attainment of African personhood under African cosmology.

When the biomedical and epidemiological approach during the Ebola outbreak asked people to not conduct various burial rites and not to touch the sick or deceased bodies of loved ones, there was a lot of resistance, as Senegalese social anthropologist Cheikh Ibrahim Niang notes in his work in Guinea, Sierra Leone and Mali.

Similarly to the West African context noted by Niang, in South Africa we have the dual resistance and distrust of the state that in pandemics such as HIV/AIDS was characterised by apathy and what has been called the period of “AIDS denialism”. This period in South African history resulted in preventable deaths of an estimated 2,65 million adult life years through states neglect and the failure to provide lifesaving antiretroviral treatment to the general population, as then recommended by the World Health Organisation.

Turning to indigenous systems for healing

This history rooted in pain and the trauma of government neglect has resulted in various forms of fatalism toward the state and political powers in South Africa, especially in relation to these powers providing assistance that prolongs life for many in the country. In the days where the state and biomedicine failed many, the accessibility of other forms of healing systems through izangoma and iinyanga were central to many of the Black population accessing healthcare outside of biomedicine.

In her wide-ranging work on social healing in South Africa, sociologist Nthabiseng Motsemme has done well to index the ways in which the violence of our past in South Africa resulted not only in mass deaths, but further violated sanctuary spaces and practices. This defilement of sacred spaces included funerals and, as Motsemme argues, had a profound impact on many Black South Africans’ abilities to have a sense of balance.

In trying to build parallels with the work that Motsemme has done, we can begin to think around the implications of this global pandemic as one that has been and, perhaps will continue to be, destructive to Black African people’s sacred spaces. This will destabilise things like traditional initiation schools for the different cultures and contexts in the continent that still perform them. For these rituals, touch, gatherings and communal fellowshipping are central to helping young people transition from one phase of life (eg boyhood) to another (eg manhood). For those people, initiation school and the ceremony that follows is not simply a moment but a continuous lifelong process that has a social significance.

In South Africa the number of people who may gather in a single location has been regulated. This means that new-born babies cannot for now undergo the crucial ritual of imbeleko – an ancestral ritual performed to introduce a newborn to their ancestors. Perhaps a Western biomedical lens would argue that families can gather for these occasions and still manage to do them successfully. Yet, this ignores that in Black communities, ceremonies and rituals are both family and community resources. These rituals are incomplete in the absence of the other. The reason for this is that when the ceremony and ritual have been conducted, the people these were done for must live, function and live fulfilling lives in these communities.

African medical problems, whether they affect the whole globe or the continent only, cannot be resolved efficiently through the biomedical system only because even though years might have passed the distraction of lives caused by biomedicine has not been forgotten by many. There has to be a rapidly growing awareness that context is imperative and some medical issues need context-based solutions as opposed to universal solutions or preventative measure.

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