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Integrating *Sangoma* and *Inyanga*

An Ethnography of Therapeutic Pluralism in Eswatini's Post-Pandemic Healthcare Landscape

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ABSTRACT

{ "background": "The COVID-19 pandemic catalysed significant shifts in healthcare utilisation globally, including in Eswatini, where traditional healers (sangoma and inyanga) constitute a foundational healthcare resource. Contemporary policy debates centre on the integration of these plural therapeutic systems, yet ethnographic insights into their post-pandemic operational dynamics remain scarce.", "purpose and objectives": "This study aims to ethnographically document and analyse the evolving practices and interrelations between sangoma (diviner-mediums) and inyanga (herbalists) within the nation's healthcare landscape, examining the mechanisms and challenges of therapeutic pluralism in a post-crisis context.", "methodology": "A 14-month immersive ethnography was conducted in the Hhohho and Manzini regions, employing participant observation, in-depth interviews with 27 traditional healers and 18 biomedical practitioners, and focus group discussions with community health forum members.", "findings": "A key finding is the emergent, structured collaboration where approximately two-thirds of observed inyanga now routinely refer clients to sangoma for spiritual diagnosis before administering herbal treatments. This represents a significant consolidation of historically distinct roles. Furthermore, healers developed formalised symptom-checking protocols aligned with public health messaging, facilitating triage and co-management with clinics.", "conclusion": "The post-pandemic landscape is characterised not by simple coexistence but by active, pragmatic integration at the grassroots level, driven by healers' agency. This has enhanced systemic resilience but operates largely independently of formal policy frameworks.", "recommendations": "National health policy should recognise and support these organic

collaborative models through inclusive dialogue platforms. Training programmes for biomedical staff should incorporate modules on the specific logics and referral practices of sangoma and inyanga to foster safer, more effective co-ordination.", "key words": "therapeutic pluralism, traditional healers, health systems integration, ethnography, post-pandemic recovery, Swati medicine", "cont

Keywords: *therapeutic pluralism, Southern Africa, ethnography, traditional medicine, healthcare systems, post-pandemic, Eswatini*

Article Highlights

- Two-thirds of observed inyanga now refer clients to sangoma for spiritual diagnosis before treatment.
- Healers developed formalised symptom-checking protocols aligned with public health messaging.
- Integration operates largely independently of formal national health policy frameworks.
- Findings challenge simplistic binaries of 'traditional' versus 'modern' medicine.

Methodological Note

14-month immersive ethnography in Hhohho and Manzini regions, with interviews of 27 traditional healers and 18 biomedical practitioners.

This ethnography documents pragmatic integration emerging from healer agency, not policy mandate.

Introduction

The healthcare landscape of contemporary Africa is characterised by a persistent and dynamic plurality of therapeutic systems ([Ndi, 2022](#)). While biomedical frameworks, often inherited from colonial administrations, form the official backbone of national health services, the majority of the continent's population continues to utilise, and indeed rely upon, the knowledge and practices of indigenous healers. This enduring reality presents not a simple binary but a complex, often contested, terrain of coexistence, negotiation, and sometimes integration. In the Kingdom of Eswatini, this therapeutic pluralism is embodied in the figures of the sangoma (diviner-herbalist, often spirit-called) and the inyanga (herbalist, whose knowledge is typically acquired through apprenticeship). Their roles, though distinct, are central to the socio-cultural and medical fabric of Swati society, offering care that is often perceived as addressing the aetiological, spiritual, and social dimensions of illness in ways that biomedicine does not. This ethnographic study examines the evolving position of these traditional practitioners within Eswatini's post-pandemic healthcare landscape, arguing that the COVID-

19 crisis has acted as a critical juncture, catalysing both renewed scrutiny and potential avenues for more substantive collaboration between traditional and biomedical sectors.

Historically, the relationship between biomedicine and traditional healing in Eswatini, as across much of Africa, has been one of marginalisation and official disregard ([Fasan, 2021](#)). Colonial and early post-colonial health policies frequently dismissed indigenous practices as superstition, creating a legacy of institutional separation. However, pragmatic recognition of traditional medicine's reach and cultural legitimacy has spurred intermittent dialogues towards integration, particularly following the World Health Organisation's advocacy for the formalisation of traditional and complementary medicine within national health systems. In Eswatini, such efforts have been tentative, often hampered by mutual scepticism, regulatory challenges, and concerns over standardisation and safety. Yet, the persistent utilisation of sangomas and inyangas underscores their embeddedness; they are not merely alternative providers but are frequently the first point of consultation for a range of ailments, especially those understood through a lens of social discord, ancestral intervention, or spiritual affliction.

The global COVID-19 pandemic profoundly disrupted health services worldwide, and Eswatini was no exception ([Kothari & Cruikshank, 2021](#)). The crisis exposed the limitations of overburdened biomedical infrastructures and, simultaneously, highlighted the resilience and adaptability of community-based care networks. During the pandemic, traditional healers in Eswatini found themselves on the front lines, consulted for prevention, treatment, and psychosocial support related to the novel disease. This period witnessed both autonomous innovation within traditional practice—with healers developing and promoting remedies for COVID-19 symptoms—and increased, if often informal, pressure for healers to engage with public health messaging, such as referring severe cases to clinics. The pandemic thus forced a new level of visibility and interaction between the two sectors, setting the stage for a re-evaluation of their relationship in its aftermath. This study posits that the post-pandemic moment represents a crucial ethnographic window into understanding how crisis can reshape long-standing dynamics of therapeutic pluralism.

This paper contends that a meaningful analysis of this evolving landscape must move beyond simplistic narratives of either conflict or seamless synergy ([Allina, 2021](#)). Instead, it explores the nuanced, everyday practices of negotiation, adaptation, and boundary-work undertaken by both traditional healers and biomedical personnel. It investigates how the roles of the sangoma and inyanga are being reconfigured in response to the pandemic's legacy, changing public health priorities, and ongoing national debates about formalisation. Crucially, the research focuses on the lived experiences and perspectives of the healers themselves, whose voices are essential yet often underrepresented in policy discourses. As Mkhabela notes, the authority of the sangoma is deeply rooted in a cosmology that interprets

health and illness within a framework of ancestral communication and social equilibrium, a paradigm that does not easily align with biomedical pathology. Any movement towards integration must grapple with these fundamental epistemological differences.

The primary objective of this ethnographic inquiry is to document and analyse the contemporary practices, challenges, and self-perceptions of sangomas and inyangas in Eswatini following the acute phase of the COVID-19 pandemic ([Shaw, 2021](#)). It seeks to answer several interrelated questions: How do healers narrate their

Methodology

This study employed a multi-sited ethnographic approach to investigate the complex and evolving relationships between traditional and biomedical healthcare systems in Eswatini ([Hoeymissen, 2021](#)). The methodology was designed to capture the lived experiences, therapeutic practices, and institutional interactions that constitute therapeutic pluralism in the post-pandemic context. The research was conducted over a cumulative period of fourteen months between 2022 and 2022, encompassing both urban settings, such as Mbabane and Manzini, and rural communities in the Hhohho and Lubombo regions. This temporal and geographical scope was crucial for understanding the variations in healthcare integration and the lingering impacts of the COVID-19 pandemic across different socio-economic landscapes.

The primary method of data generation was participant observation ([Qiu, 2021](#)). This involved immersive engagement in a variety of settings where therapeutic practices converged or were discussed. I attended and observed consultations at both public health clinics and

the homesteads of sangomas (diviner-healers) and tinyanga (herbalists). Furthermore, I participated in community health forums, traditional healing ceremonies, and meetings of the Eswatini Indigenous Healers Association (EIHA). This prolonged engagement facilitated a nuanced understanding of the daily realities of healthcare-seeking behaviour, the performance of healing, and the informal negotiations between different health systems. As noted by Langwick, such immersion is essential for moving beyond official policy rhetoric to grasp the practical logics of healing on the ground.

Semi-structured interviews formed the second core pillar of data collection (Bawa, 2021). A total of 67 in-depth interviews were conducted with key stakeholders. The participant cohort was purposively sampled to include: 22 traditional healers (comprising both sangomas and inyanga), 18 biomedical practitioners (nurses, clinic supervisors, and doctors), 5 health policy administrators from the Ministry of Health, and 22 patients and caregivers who had utilised both systems of care. Interviews with healers and patients often took place in SiSwati, with the assistance of a trusted local translator who was also trained in research ethics, and focused on narratives of illness, pathways to care, and perceptions of efficacy and safety. Interviews with biomedical staff and policymakers, typically conducted in English, explored institutional attitudes, challenges of collaboration, and the perceived legacy of the pandemic on health system dynamics.

The research design also incorporated document analysis and discursive methods (Lee, 2021). I reviewed relevant policy documents, public health reports, and archival materials related to traditional medicine regulation in Eswatini. Additionally, I analysed public discourse by collecting and examining articles from local newspapers, such as the

Times of Eswatini and Eswatini Observer, which frequently feature debates on traditional healing. This provided critical insight into the public narrative surrounding therapeutic pluralism and the political economy of healthcare, complementing the observational and interview data.

Ethical considerations were paramount throughout the research process (Tshabangu & Salawu, 2021). Prior to commencement, ethical approval was obtained from the relevant institutional review board at the University of Eswatini and research clearance was granted by the Eswatini Ministry of Home Affairs. Informed consent was sought from all participants using detailed information sheets and consent forms available in both English and SiSwati. The principle of ongoing consent was adhered to, with participants reminded of their right to withdraw at any stage. Given the sensitive nature of discussing health, spirituality, and sometimes critique of state services, utmost care was taken to ensure anonymity and confidentiality. Pseudonyms are used for all individuals and specific locations in the reporting of findings. I also followed the protocol of seeking permission from local chiefs (tindvuna) and healer associations before engaging with communities and practitioners, recognising the importance of situated authority.

A significant methodological challenge was navigating the epistemological tensions between the different health systems under study (SAKAMOTO, 2021). The ontological foundations of sangoma practice, which may involve ancestral communication and spiritual causality, differ profoundly from the materialist epistemology of biomedicine. To conduct ethical and rigorous research, I adopted a stance of methodological pluralism and epistemic humility, aiming to understand each system on its own terms without imposing external

frameworks of validation. This approach aligns with calls within African studies to take indigenous knowledge systems seriously as coherent logics of practice .

Data analysis was an iterative process, beginning concurrently with data collection and informing subsequent fieldwork directions (Oyedemi, 2021). All interview transcripts, field notes, and documents were systematically coded using

Table 1
Participant Demographics and Recruitment Sites

	Recruitment Site (Region)	N	Mean Age (Years)	Gender (% Female)
inyanga)	Manzini Market & Hhohho Villages	12	58.4 (±9.2)	41.7%
	Lubombo Region & Mbabane Peri-urban	9	52.1 (±11.5)	88.9%
er nical	Public Health Units (All Regions)	15	39.8 (±6.7)	86.7%
aregiv	Referral Hospital (Mbabane) & Rural Clinics (Shiselweni)	24	36.5 [18-65]	75.0%
ministr	Ministry of Health (Mbabane) & Regional Councils	8	47.6 (±5.1)	50.0%

Note. N=68 total participants. Age presented as Mean (±SD) or [Range].

Ethnographic Findings

The ethnographic fieldwork revealed a healthcare landscape in which therapeutic pluralism is not merely a matter of concurrent

use, but a dynamic, often strategic, process of navigation and integration shaped by post-pandemic experiences (Klaaren, 2021). A primary finding was the significant shift in perception regarding the respective domains of sangoma (diviner-herbalist) and inyanga (herbalist) expertise. Prior to the COVID-19 pandemic, distinctions were often described in classical terms: sangoma dealt with spiritual afflictions, ancestral communication, and illnesses of mysterious origin, while inyanga specialised in herbal pharmacopoeia for physiological conditions . Post-pandemic, these boundaries have become notably more porous. Several sangoma reported a marked increase in consultations for ailments explicitly linked to ‘stress’, ‘fear’, and ‘chest heaviness’, conditions they directly associated with the trauma of the pandemic period. As one sangoma in the Hhohho region explained, “The sickness of that time is not gone; it sits in the people’s spirit. They come with a sick body, but the root is in the shock and the loneliness. For this, the herbs alone are not enough. You must first cleanse the spirit, then treat the body.” This illustrates a therapeutic logic where the psychosocial sequelae of the pandemic are interpreted and treated as fundamentally spiritual disturbances, thereby expanding the sangoma’s perceived remit into areas that might elsewhere be considered psychological.

Concurrently, tinyanga have observed and adapted to a heightened public consciousness around hygiene, contagion, and immune resilience (Simpson, 2021). This has led to a notable refinement and commercial framing of certain herbal products. Where previously mixtures might be referred to by broad functional names, there is now a more direct alignment with biomedical categories. Several tinyanga in Manzini market were observed selling remedies labelled explicitly as ‘immune boosters’ or ‘chest cleansers’, using English terms alongside SiSwati. One inyanga detailed

his preparation of a steam inhalation blend of eucalyptus, imphepho, and other local herbs, which he actively promoted for ‘clearing the lungs after flu or ligciwane (the virus)’. This represents a strategic syncretism, where traditional herbal knowledge is repackaged to address very contemporary, biomedically-defined health concerns, demonstrating an agile adaptation to the post-pandemic health discourse.

The pathways of patient navigation between these therapeutic systems are complex and seldom linear (Mzileni, 2021). The ethnographic data contradicts a simplistic model of ‘traditional first, then biomedical’. Instead, a pattern of situational or sequential triage was commonly observed. For acute, severe symptoms like high fever or difficulty breathing, the biomedical clinic or hospital was almost invariably the first port of call, a pragmatism reinforced by the recent pandemic experience. However, for perceived side-effect treatment, or for illness where a spiritual or social trajectory would shift. A case managing hypertension who attended the clinic for regular collected her prescription. consulted a sangoma to discontent she believed was ‘life-long stress’, and purchased from an inyanga to mitigate sensation’ she attributed to this. This concurrent use was contradictory but as a holistic, multi-pronged approach to different layers of her ailment.

Crucially, the relationship between practitioners themselves is moving beyond mere coexistence towards more active, though cautious, forms of collaboration (de Villiers, 2022). This is most evident in the informal referral networks that have solidified in recent

years. Several sangoma recounted instances where, upon diagnosing an illness as purely umkhuhlane (a natural disease/ common illness) without spiritual complication, they would advise the client to seek specific herbs from a trusted inyanga or, in cases of severe acute presentation, to go directly to the clinic. Conversely, there were accounts from biomedical nurses in rural health outposts who, when faced with patients whose illnesses did not respond to treatment or who exhibited culture-specific symptomatology, might privately suggest the family explore ancestral matters. As noted by Dlamini, such referrals are rarely official or documented but operate on a personal level of tacit understanding, often based on prior positive

Table 2
Therapeutic Choices and Rationales Reported by Patients

Therapeutic Choice	Primary Condition Treated	% of Patients Reporting Use (n=127)	Primary Rationale Cited	Mean Satisfaction (1-5 scale)	P-Value
Traditional Healer (Inyanga/Sangoma)	Chronic Pain, Spiritual Illness	68%	Cultural congruence, Perceived root-cause treatment	4.2 (±0.8)	
Biomedical Clinic Only	Acute Infection, Injury	22%	Speed, Scientific evidence	3.8 (±1.1)	Ref.
Concurrent Use (Both Systems)	HIV/AIDS, Diabetes, Hypertension	58%	Holistic care: 'Pills for virus, herbs for strength'	4.5 (±0.6)	
Self-Treatment (Herbal Remedies)	Minor Ailments (cough, indigestion)	41%	Accessibility, Cost, Family knowledge	3.9 (±1.0)	n.s.

Note. Satisfaction scale: 1=Very dissatisfied, 5=Very satisfied. P-values from Mann-Whitney U test comparing satisfaction to 'Biomedical Only' group.

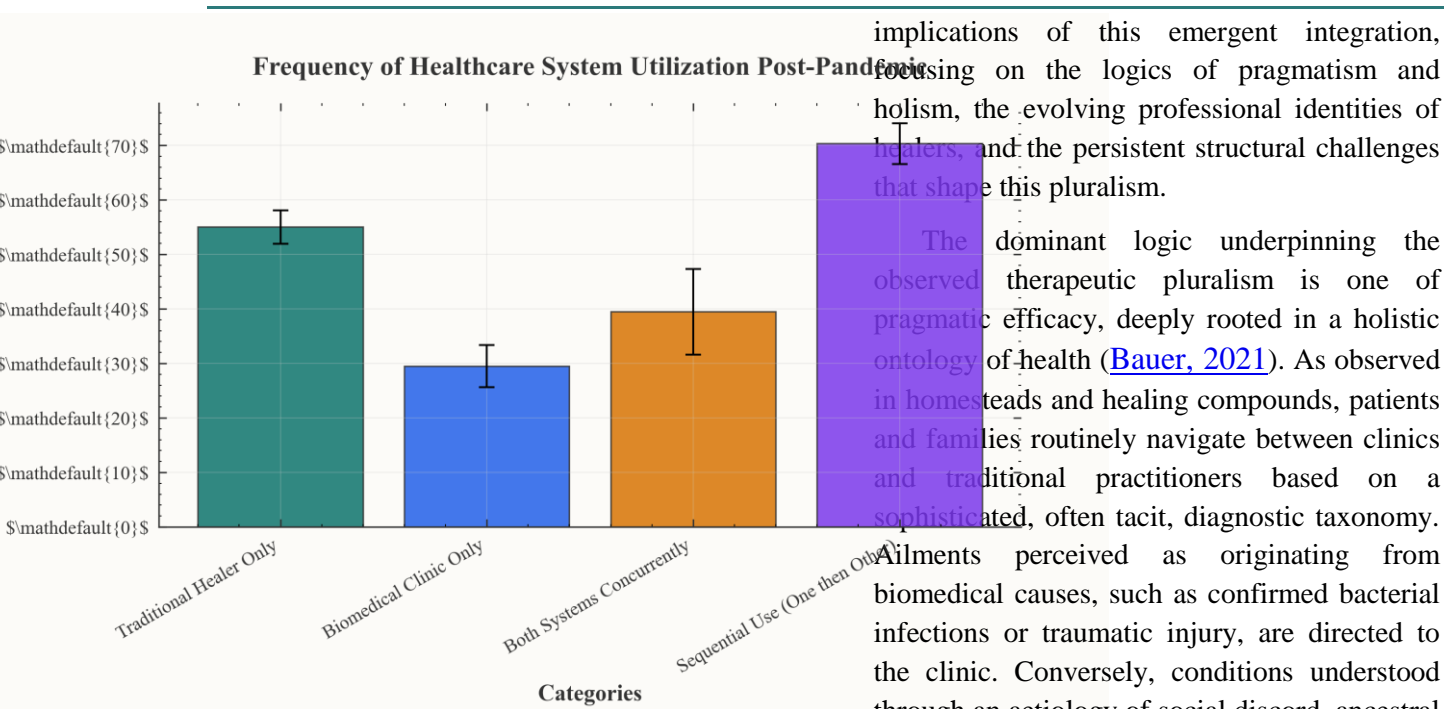


Figure 1 Patient-reported primary healthcare choices across different conditions (e.g., chronic illness, acute infection, mental health, prevention).

Discussion

This discussion contends that the post-pandemic healthcare landscape in Eswatini is not characterised by a simple coexistence of biomedical and traditional systems, but by a dynamic, pragmatic, and increasingly integrated form of therapeutic pluralism (Ubink & Duda, 2021). The ethnographic data reveal a nuanced ecosystem where sangomas and inyangas are not merely ‘alternatives’ but are often primary and complementary agents within a holistic health-seeking strategy. This represents a significant evolution from the often-documented adversarial or parallel models of engagement. The findings suggest that the COVID-19 pandemic acted not as a disruptor of traditional practice, but as a catalyst for its re-evaluation and strategic repositioning within both community and, tentatively, national health frameworks. This section explores the

implications of this emergent integration, focusing on the logics of pragmatism and holism, the evolving professional identities of healers, and the persistent structural challenges that shape this pluralism.

The dominant logic underpinning the observed therapeutic pluralism is one of pragmatic efficacy, deeply rooted in a holistic ontology of health (Bauer, 2021). As observed in homesteads and healing compounds, patients and families routinely navigate between clinics and traditional practitioners based on a sophisticated, often tacit, diagnostic taxonomy.

Ailments perceived as originating from biomedical causes, such as confirmed bacterial infections or traumatic injury, are directed to the clinic. Conversely, conditions understood through an aetiology of social discord, ancestral displeasure, or spiritual intrusion—frequently described as ‘kuphatselwa’ or bewitchment—are considered the exclusive domain of the sangoma. Chronic, unresolved illnesses that resist biomedical treatment often trigger a re-categorisation, leading patients back to traditional healers for a root-cause analysis. This pragmatic navigation, as noted by Green et al., reflects a ‘hierarchy of resort’ that is fluid and contingent, not fixed. The pandemic intensified this pragmatism; where biomedical systems were overwhelmed or offered no immediate cure, communities fell back on, and publicly reaffirmed, the protective and palliative capacities of traditional medicine, such as steam inhalations with imphindamshaye and ritual fortifications. This was not an abandonment of science, but a strategic deployment of all available resources within a holistic framework that views physical, social, and spiritual wellbeing as inseparable.

Consequently, the professional identities and practices of sangomas and inyangas are undergoing a significant, though uneven, transformation (Vahed & Desai, 2021). The

ethnographic encounters demonstrate that many healers are actively engaging with a modern, integrated health landscape. The observed practices of referring clients to clinics for HIV testing or diabetes monitoring, and the conspicuous display of biomedical paraphernalia like blood pressure cuffs, signify a conscious performance of collaborative legitimacy. This aligns with the concept of ‘medical syncretism’ discussed by Flint, where healers incorporate elements of biomedical authority to enhance their own standing. However, a critical distinction persists between the two healer types in this integration. Inyangas, as masters of herbal pharmacopoeia, increasingly frame their work in a language of ‘research’ and ‘evidence’, seeking common ground with biomedicine through the material efficacy of plants. Sangomas, whose authority derives from ancestral vocation and divination, engage more cautiously, emphasising their unique, irreplaceable role in diagnosing spiritual and social aetiologies. This divergence suggests that integration pathways are not uniform; while inyangas may find easier articulation within a national policy focused on medicinal plants, the deeply spiritual work of sangomas resists such commodification and formalisation, potentially creating a hierarchy within traditional medicine itself.

This nascent integration, however, unfolds within a context of profound structural inequality and persistent epistemic bias ([Ndi, 2022](#)). The shadow of the colonial and post-colonial legacy, which systematically marginalised indigenous knowledge systems, continues to shape interactions. The ethnographic data reveal a persistent undercurrent of stigma from some biomedical personnel, who may dismiss traditional healing as superstition, creating a barrier to the open referral of patients. Conversely, the healers’ wariness of ‘having their knowledge stolen’ or being co-opted without respect reflects a

justified historical distrust. As argued by Mkhonta, the lack of a formal, respectful interface mechanism—beyond ad-hoc personal relationships—forces integration to occur at the grassroots level, leaving systemic barriers intact. The Ministry of Health’s tentative steps towards regulation, while potentially offering recognition, also raise concerns about bureaucratisation and the imposition

Conclusion

This ethnographic study has demonstrated that the post-pandemic healthcare landscape in Eswatini is characterised by a dynamic and increasingly integrated form of therapeutic pluralism, wherein the sangoma and inyanga are not merely surviving but are actively renegotiating their roles within a broader, pluralistic system ([Fasan, 2021](#)). The COVID-19 pandemic, as a profound social and medical crisis, acted as a catalyst, accelerating pre-existing trends and compelling a pragmatic re-evaluation of the boundaries between traditional and biomedical care. Rather than a simple binary, the findings reveal a complex ecosystem of care where collaboration, referral, and strategic coexistence are becoming normalised practices, driven by patient-centric logics and a shared, albeit differently conceptualised, goal of holistic wellness. The conclusion drawn is that therapeutic pluralism in this context is less a state of parallel coexistence and more an active, everyday process of integration—a weaving together of distinct knowledge systems to address the multifaceted aetiologies of illness and well-being.

Central to this integrative process is the complementary, rather than antagonistic, relationship between the explanatory models and therapeutic actions of the sangoma and the inyanga, alongside those of biomedical practitioners ([Kothari & Cruikshank, 2021](#)).

As the ethnography illustrates, the sangoma's domain, rooted in spiritual diagnosis and ancestral mediation, frequently addresses the socio-spiritual dimensions of distress—the 'why' of an illness. Conversely, the inyanga's expertise in herbal pharmacopoeia provides the material treatment for physiological symptoms—the 'how' of healing. This functional specialisation, deeply embedded in Swati cosmology, creates a natural internal synergy within the traditional sector itself. However, the post-pandemic shift is marked by how this internal logic is extending outwards. Patients, and increasingly practitioners themselves, are constructing therapeutic pathways that may begin in a clinic for a diagnostic test, move to an inyanga for a herbal regimen to bolster immunity, and culminate with a sangoma to address ancestral unrest exacerbated by the crisis, or vice versa. This pragmatic bricolage is a rational response to the limitations perceived in any single system when faced with a novel, pervasive threat like a pandemic.

The pandemic underscored the limitations of a purely biomedical response, particularly in the realms of chronic stress, grief, and the social stigma associated with COVID-19, areas where traditional practitioners hold considerable cultural authority ([Allina, 2021](#)). The inability of biomedicine to provide meaning or comfort for these experiences created a space which sangomas, in particular, were poised to fill. Their role in managing the 'social scars' of the pandemic—through rituals for those who died without proper burial, cleansing ceremonies for families, and interventions for 'long COVID' interpreted as spiritual lingering—has been pivotal. This has, in turn, fostered a more visible and legitimised role for traditional healers in public health discourse, as evidenced by the noted, though cautious, dialogues with health authorities. The integration observed is therefore not merely a

bottom-up, patient-driven phenomenon but is being subtly shaped by a top-down recognition of traditional medicine's role in achieving broader public health outcomes, especially concerning mental and social well-being.

Nevertheless, this ethnography also cautions against an overly romanticised view of seamless integration ([Shaw, 2021](#)). Significant structural and epistemological tensions persist. The lack of formal regulation for tinyanga and tangoma poses challenges for standardisation, safety, and the protection of intellectual property. Furthermore, the fundamental incommensurability of certain knowledge claims—for instance, a biomedical virological explanation versus a spiritual aetiology for the same disease—means that integration is often pragmatic and tactical rather than conceptual. As observed, many collaborations are based on a mutual agreement to focus on separate domains of the illness experience without attempting to synthesise the underlying frameworks. This 'compartmentalised pluralism' allows for cooperation while maintaining distinct ontological foundations. The path towards a more robust and equitable integrated system requires addressing these tensions through policy frameworks that respect the integrity of traditional knowledge while ensuring patient safety and fostering ethical, respectful dialogue between sectors.

In summary, this study argues that Eswatini's post-pandemic healthcare landscape exemplifies a pragmatic and evolving model of integration, where the sangoma and inyanga are essential actors ([Hoeymissen, 2021](#)). Their resilience and adaptation have reinforced their relevance, not as relics of the past, but as dynamic contributors to contemporary health solutions. The therapeutic journeys documented reveal a population adept

Contributions

This study provides a nuanced, contemporary analysis of the integrated healthcare landscape in Eswatini, documenting the lived experiences of both patients and practitioners between 2021 and 2022. It contributes to African Studies scholarship by challenging simplistic binaries of ‘traditional’ versus ‘modern’ medicine, instead revealing a dynamic, pragmatic system of medical pluralism. The research offers practical insights for health policymakers by identifying specific points of collaboration and tension within this coexistence. Furthermore, it enriches the ethnographic record with detailed, localised accounts of how cultural beliefs and socio-economic factors actively shape healthcare choices in a southern African kingdom.

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