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Explanation and Uncertainty in the Medical World of Ghaambo

STEVEN FEIERMAN

One of the central questions about African healing practices, a question asked many times during the past sixty years, is how they can be compared to science, and particularly to science-based medicine. E. E. Evans-Pritchard, in his famous study of 1937, assessed the worth of Zande oracles and therapeutic magic as a system of natural observation and prediction. He observed Zande practices, and from them he abstracted chains of causal reasoning, which he found to be flawed when evaluated according to the standards of “science” and “logic.” Thirty years later, Robin Horton returned to the same issues. In an article section entitled “Divination versus Diagnosis,” he argued that African folk-reasoning about disease leaves no room for disproof. He described traditional African reasoning as “closed,” so that it systematically blocked out alternatives to accepted causal explanations. Science, by contrast, is “open.” In the decades since then, positions have changed, but the core scientific comparison lives on. In 1997 Roy Porter described colonial attacks on African and South Asian healers. His own assessment of popular medicine was sympathetic, but he continued the practice of measuring it by scientific standards. “Popular medicine,” he wrote, “has by no means always been misguided or erroneous. Recent pharmacological investigations have demonstrated the efficacy of many traditional cures.”¹ A 1999 exploration of twenty Web sites on “African traditional medicine” found that three quarters of them were concerned with the efficacy of herbal

I am grateful to Charles Rosenberg, Henrika Kuklick, Stacey Langwick, Eve Buckley, Sandra Barnes, and the anonymous *Bulletin* reviewers for their comments on earlier drafts of this article.

1. Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to Present* (New York: W.W. Norton, 1997), p. 37. See E. E. Evans-Pritchard, *Witchcraft, Oracles and Magic among the Azande* (Oxford: Clarendon Press, 1937), pp. 12, 63, 76–77, 492–93, 504. Evans-Pritchard made a sharp distinction, throughout his book, between mystical

medicines; the underlying assumptions about efficacy were materialist/mechanistic ones.² In this latest generation the rhetoric of multicultural participation is new, but the core comparison of “traditional” thought and Western science persists, from Evans-Pritchard to the World Wide Web.

The story of this persistence raises serious questions. Are the underlying criteria appropriate ones, or do the very standards of efficacy miss the point? Would the people who actually used “traditional” medicine judge it in the same way? Within African societies where local forms of healing were practiced, were the actions of herbs as material objects seen as having a direct effect on the body-as-mechanism? When patients or practitioners assessed the value of a course of therapy, were they interested in it primarily as a set of actions in the material world, or were they assessing therapy (and the underlying problem) on some other basis? There appears to be a substratum of universal experience—the universality of pain and the desire for relief—but even this is misleading, for “pain” and “relief” change from one society to another, even from one individual to another. In an important sense the questions asked here are unanswerable, because they are cast in terms of the African continent, which has more than three times the land area of the United States, is enormously diverse in its cultures, and is occupied by people who speak between 750 and 1,000 languages.

notions and common-sense notions. “Our body of scientific knowledge and Logic,” he wrote, “are the sole arbiters” in making this distinction (p. 12). He says, for example, that “when a man digs a hole to trap animals he acts empirically and explains his behavior in a common-sense way; but when, having dug the hole, he strips naked and jumps over it, we do not regard his action as empirical because it in no way affects the movement of animals as it is believed to do” (p. 492). He also explains that “witchcraft . . . is not an objective reality” (p. 63). At another point in his argument he asks, “What difference can we observe between the behaviour of Azande when they are using drugs which are of real therapeutic value and their behaviour when they are using drugs of no therapeutic value?” (p. 504). See also Robin Horton, “African Traditional Thought and Western Science,” *Africa*, 1967, 37: 50–71, 155–87, esp. pp. 169–72.

2. The Web search was conducted on 22 July 1999 using Netscape as the search engine. The search terms were “Africa” and “traditional+medicine.” Of the first 20 Web sites listed, 15 were concerned with the efficacy of herbal medicines; 2 were concerned with traditional healers as public health collaborators (for example, in convincing people to agree to be immunized); 2 were general statements for American or European audiences on the spiritual and health benefits of traditional approaches to medicine; and 1 was concerned with the trade in wildlife and herbs, as it might affect the future preservation of biological resources. If a single Web site appeared under multiple headings, it was counted once. In several cases, the search engine listed the URL (or address) of a site that then could not be found; possibly a site that had once been active was now closed. When this happened, additional sites further down the list were called up to keep the total number consulted at 20.

Because of this complexity, and because of the difficulties of cultural translation,³ I can offer no more than a sketch, with reflections, on one small place—a single village in northeastern Tanzania where, for a period of two and a half years (between 1979 and 1981), three researchers recorded interviews with patients and their caregivers about the causes of illness and the efficacy of therapies. Ghaambo was then a village of about seven hundred people, all of whom spoke the Shambaa language, and most of whom also spoke Swahili, the national language of Tanzania. I was one of the record-keepers during the first eleven months of the period (from July 1979 to June 1980). Each day I walked from household to household, visiting as many as I could, asking people about their current illnesses, what healing actions had been taken, who had decided on them, who had paid, and what the patients or caregivers understood to be the causes of the illness and the nature of the therapy. I was fluent in Shambaa (and in Swahili), and took notes while listening, often verbatim. The illness narratives I recorded were supplemented, for the same period, by the medical records of Elizabeth Karlin, a physician who also spoke Shambaa. She carried out physical examinations and nutritional measurements on nearly all the people in the village, and also recorded medical histories for many of them. We referred patients to Bumbuli Hospital, several miles away (where she also worked), and she sometimes treated people on the spot, in the village. Up to June 1980 Martin Msumari Shembago, who was himself from Ghaambo, worked as my assistant. He accompanied me on my daily rounds, and we discussed what we had seen and heard. From June 1980 until the end of 1981 he continued to visit households by himself, to inquire about illnesses and to write down personal illness narratives and descriptions of therapies. The narratives of particular individuals and of households unfold in the records over the whole of the two-and-a-half-year period. During that time some patients died, others were cured, and still others came to terms with chronic illness.⁴ Often the account of a single illness tells of different therapies at different times, of periods when the patient improved and when she declined. It sometimes records the changing moods of the patient and the caregivers, and the variable interpretations of illness and therapy.

The records of Ghaambo are supplemented by yet another set of records, made in 1968, of my studies with a number of “traditional”

3. Barry Hallen and J. Olubi Sodipo have addressed the question of the indeterminacy of translation in relation to African therapeutic ideas: *Knowledge, Belief, and Witchcraft: Analytic Experiments in African Philosophy*, 2d ed. (Stanford: Stanford University Press, 1997).

4. On narrative in relation to illness, see Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).

healers in the same general region, culminating in a formal apprenticeship to one healer. The records of 1968 describe the world from a healer's point of view; those of the later period take the viewpoint of patients and their families (although some of the patients were themselves healers).

This article is thus based on the study of an archive of which I myself was a creator. I speak in terms of my bifurcated self, as consumer and creator of archives, because the records in question were created some time ago, and I have tried to approach them in the spirit of a historian reading a set of documents for the first time—learning about their subject, and questioning the motives and viewpoint of each document's author. I am trying not to use them in an ethnographic spirit—as aids to memory, in a genre that privileges personal experience and personal observation—but am instead reading them (in Marc Bloch's phrase) as “evidence in spite of itself.”

Illnesses of God, Illnesses of Person

A conceptual space existed, within the medical world of Ghaambo, for illnesses in which the body was treated as a material object, to be cured with medicines that worked just because they worked, and not because of moral, religious, or social forces. In the Shambaa language, as in many of the Bantu languages of eastern, central, and southern Africa, an “illness of God” (*utamu wa muungu*) is an illness that happens without any spiritual or social cause—it happens because it happens, as an event in the world of material objects. The usual contrast is with an “illness of person” (*utamu wa mntu*), an illness caused by someone's hostile or aggressive actions. The two categories are not meant to be a systematic classification of a total field; there are conditions that fall into neither one. An aged healer named Shemng'indo⁵ described the relationship between the two categories in a discussion of *duazi*, a disease entity characterized by congestion of the chest, or by swelling:

There is the *duazi* of medicine-making and the *duazi* of God. These trees—these herbs—are the herbs of God. If the illness is one of God, [then once treated with these herbs] it will be cured. But the same herbs are also the ones that cause the illness if a person transforms them. . . . The same herbs that heal can be transformed so as to cause the condition. (20 September 1979)

Shemng'indo contrasts *duazi* as a “natural” condition (“the *duazi* of God”), and *duazi* as a consequence of sorcery (“of medicine-making”), but to the patient who is suffering from a cough, the diagnosis is not

5. Pseudonyms are used for all healers and patients mentioned in this article.

immediately clear. The condition might be *duazi* or some other condition; if it is *duazi* it might be “natural” or the result of aggression; and even then there is ambiguity, for there are many possible forms of the technology of attack.

As we shall see, patients often moved from one therapy to another, and then to another, in the process of deciding whether a particular condition was an “illness of God,” or an “illness of person,” or perhaps an illness caused by a nonhuman being, or a spirit of some kind. The movement from one treatment to another (from hospital, to sorcery treatment, to spirit-possession ceremony) was a kind of diagnostic trial and error, an elimination of diagnostic possibilities.

As the diagnostic process unfolded, patients and their relatives often engaged in a broad-ranging inquiry, questioning received assumptions about medicine. They questioned the skill of practitioners and the validity of knowledge, whether folk or biomedical. The record of these reflections challenges the belief, held in Europe and the United States (and among some African physicians and health workers), that African folk understandings are characterized by an unreflexive certainty—that they are based on a static body of knowledge, accepted because it has been received from the past. The narratives about Ghaambo are filled with uncertainty at every level: uncertainty about the status of expert knowledge, about how the body works, and about the likelihood of isolating one possible disease-cause from among many. The narratives are emphatically nonreductionist.

Hospital treatments are associated with the domain of “illnesses of God,” and it is in this domain that comparisons with science fit the most easily. It is therefore appropriate to describe illnesses that just happen before moving on to other varieties of illness causation. We will see that even in illnesses of God, interpretations of the disease process and of treatment are not narrowly reductionist. Only by exploring subtle variations in reasoning about the interaction between the person and the disease entity, or the person and the medicine, can we begin to understand the problems people were addressing when they spoke about healing and illness. And only then can we see how the comparison with science leads us away from their concerns.

Above and Below the Water Barrier

Before beginning with “illnesses of God,” we must consider background statements reporting local understandings of anatomy and physiology. To frame descriptions in terms of a “folk anatomy” or a “folk physiology” is in some sense an act of violence against thinkers from the region

around Ghaambo, who were frank about the fact that they had little experience at examining the internal organs of humans, although they took some care in studying animals' organs. Their therapeutic knowledge was the fruit of much more careful inquiry about things that could be perceived without penetrating the body: about observable symptoms, and about sensations described by the patient. Local thinkers then reasoned about the combinations of symptoms that constituted a syndrome, and about chains of causation and cure. It is important not to picture local understandings as a closed system. "Traditional" healing was a site of continuing change and innovation. And new elements were also being introduced in school, on the radio, in government meetings, or from those who had studied Islamic healing arts. Some villagers were schoolteachers, others minor government functionaries, and still others teachers of Islam.

I will begin with a simple distinction: between diseases that affect the lower half of the body cavity, among them *shango*, and diseases of the upper half, including *duazi*. First, two brief descriptions of the basic distinction; in both cases the men were responding to direct questions by me about how things work inside the body.

The *ukinda mazi* [literally, the "water barrier"; probably the diaphragm] is in the middle. . . . Even a cow has an *ukinda mazi*. The things that are below it are prevented from rising, and the things above are prevented from shifting downward. (Msonga, 18 April 1968)

The *ukinda mazi* is a barrier, so that the heart should not come into contact with the intestines. It resembles a flat winnowing basket. Diseases of the gut [in the lower half] are characterized by burning sensations. Diseases of the lungs [in the upper half] are characterized by swelling. If there is a burning sensation in the lungs, the source is the gall bladder. . . . In days of harsh sun [during the hottest part of the dry season, in January] you have a burning sensation in your mouth. It is [caused by] gall. (Asumani Kihinga, 17 April 1968)

The second explanation moved rapidly away from questions of how organs were arranged inside the body, and toward the safer ground of symptoms and sensations—burning and swelling, as labeled in relation to the organs. We can see this play out more directly in discussions of *shango*.

The following quotation, which implicates *shango* in a range of disease entities, might be confusing to the reader unless it is understood that *mshango* (literally a "worm," plural *mishango*) is a completely different thing from *shango*:

The things inside a person are unknown. We only attempt approximations [*titabunia du*]. . . . *Shango* is located inside. It rumbles [*jitatuntuma*]. *Shango* is always there, but it is usually inactive. We don't know where it lives; we only hear when it rumbles. *Shango* is a problem when the abdomen is overfull with food. *Shango* is the gut of *bukwa* when the abdomen is overfull with food. *Shango* is the large intestine . . . when it doesn't get good things. At times you have one *mshango*. That *mshango* reproduces *mishango* ["worms"]. But the big one is never excreted. If a child is very hot on the nape of the neck, it is the action of that worm. The worm is in conflict with *mpeho* ["cold," or "wind"]. *Kifafa*,⁶ epilepsy, is a worm that causes the head to fall. The worm is aroused by gall. The *mshango* ["worm"] has entered an extreme state. The *mshango* is brought to the boil. . . . But it is the *shango* that arouses the gall [and other conditions]. . . . Its medicine is fat. If you cook an infusion of wild herbs [to treat *shango*] you must put a bone in the pot. In *shango* of *ngii* [of "the warthog"], *shango* is transformed [*shango jahituka*]. It seizes you in the back. If you work for a long time at cultivating rice your back aches. It is *shango ja ngii* ["the *shango* of the warthog"]. (Shechango, 19 April 1968)

The healer made a clear statement that what is inside the body is unknowable ("the things inside a person are unknown"), and explained that his understanding is based on things that can be perceived without going beneath the skin: "We don't know where it lives; we only hear when it rumbles." He then went on to show how the terms associated with very different kinds of conditions are linked together in a complex chain (from rumblings in the stomach to a child's fever, to epilepsy, to back-ache).

This description of *shango* treats it as a disorder that occurs entirely in the realm of material objects, in which the body and its parts function as a system; it makes no mention of how the system might relate to social or moral relations. The treatments are similarly in a domain that we would be tempted to call "natural" in English; they include fatty foods and herbs of the wilderness. Both the explanation and the treatment are strikingly different from biomedical ones, but they are congruent with Western medicine in defining a domain separate from social or moral relations. Patients' narratives support this view. When they spoke about their way of dealing with *shango*, they told of using herbal treatments:

Neema [my two-year-old] has had a bit of diarrhea since yesterday. The medicine that I gave her was *leza* [*Crassocephalum bojeri*] because of the thought that the condition is *shango*.⁷ And just now she seems to have gotten a bit better. Thank goodness that medicine helped her. I gave her the *leza* this

6. The healer uses the Swahili word here. It has fewer diagnostic ambiguities, for the reader thinking in biomedical terms, than any of the related Shambaa words would have.

7. Botanical names in this paper are taken from G. R. Williams Sangai, *Dictionary of*

morning. I took the leaves and rubbed them in my hands, to break them up, and then I boiled them and gave it to her in a cup. (Zaina Hemedi, 24 June 1981)

Patients gave straightforward descriptions of the efficacy (or failure) of each therapy:

As for me, both my legs ache; even walking is a bitter experience. . . . I drank medicine of *shango*. I drank it this morning. It is *shaghamba* [*Cissus integrifolia*]. I combined it with water and made a strong infusion and now I'm drinking it when I would otherwise drink water. Even when I just get thirsty, I drink *shaghamba* water. Now let's see if it helps me at all. [Then, two days later, the patient reports:] I drank the *shaghamba* but it didn't really help me. (Shekumlughu, 4 June 1981)

While *shango* is a disease of the region below the diaphragm, *duazi* originates in the region above it. It too is treated with herbal or dietary therapies. Diseases of the upper region are characterized by swelling:

[*Duazi*] affects the chest, which may swell up. If it went on from there it takes hold of the knees, which swell. But it is a matter of the chest. It begins with some coughing and then moves on to a place where there are bones. A really terrible cough is the disease *nkambaku* ["the bull"]. The reason for the cough is food; when the breath climbs upward. . . . If the breath is not engaged in cleaning, the chest is filled with filthy things. There is a lot of phlegm, which is not moved upward. (Cha Mzighi, 20 April 1968, text 1).

This speaker, a distinguished healer, went on to describe the path taken by the breath, through a series of digestive organs and then back upward through the chest. Because of the movement of the breath through various parts of the stomach system, diet plays a role in causing *duazi*, especially when fatty foods clog the pathways.

Social and Material Intertwined

Medicines and Words

It appears here that the description places *duazi* firmly within a domain in which the organs of the body are affected by diet and by herbs, understood entirely at a material level. This approach would easily be understood by international health-care planners who advocate that biomedical researchers assimilate and adapt the herbal knowledge of the

Native Plant Names in the Bondi, Shambaa and Zigua Languages with Their English and Botanical Equivalents (n.p. [Nairobi? East African Herbarium?]), January 1963).

waghanga wa Kishambaa—the local healers (literally, “healers in the Shambaa style”). But a closer examination of the operations performed by the *waghanga* demonstrates a very different approach to the herbs. The most popular *duazi* medicines are compounded by healers from a number of herbs; the *duazi* gourd of my mentor, in 1968, included eight. Under these conditions (the use of multiple herbs instead of one, and administration by a healer instead of a layperson), there is a change in the style of preparing herbs. The healer uses ritual speech to address each ingredient, transforming it and activating its therapeutic properties. As one of the patients in 1979 explained, “I was given medicine at Kwe Hangala by an *mghanga* named Shekibinda. He does the full job—addressing the medicines with ritual speech [*atabana kabisa*]. It’s the medicine of *duazi*” (Anna Ezekieli, 5 October 1979).

Addressing the herbs was an indispensable element in the technics of healing, for the medicines in this case take on the capacity to cure only after they have been transformed through the spoken word. *Mbui* (or *mbuli*), which can be taken to mean “a word,” can also be translated as “a discrete social act.” People say *mbui izashia*, “the matter [or the word, or the affair] has ended.” A proverb tells us *Mbui yashia, ngano nkashia*, “the social act (or word) comes to an end, but thoughts about it have no end.” The healer who addresses the herbs is thus moving across what might otherwise be taken as separate domains, treating an interaction with a material object as though it were a social relationship. This movement across domains is familiar in North American life, in a variety of ways. For example, when people pray by the bedside of a patient who is receiving hospital treatment, they do not usually separate out the therapeutic effect of the prayer from that of the medicine. In other American contexts, moral transactions are treated as though they deal entirely with material things. Renée Fox and Judith Swazey, writing about organ transplantation, describe physicians who treat the transfer of an organ from one person to another as though it were an entirely mechanical process, and describe the donated heart, or lung, or kidney as a “spare part.”⁸ Some patients resist this; they treat transplanted organs as profoundly important gifts, which create permanent bonds between donors and donees. Whereas the transplant surgeons described by Fox and Swazey read the logic of things onto a moral and social relationship, in Ghaambo the formulaic words read a social and moral logic onto material things.

8. Renée C. Fox and Judith P. Swazey, *Spare Parts: Organ Replacement in American Society* (New York: Oxford University Press, 1992); idem, *The Courage to Fail: A Social View of Organ Transplants and Dialysis* (Chicago: University of Chicago Press, 1974).

In the Shambaa-speaking region, when the healer addresses the herbs, the words and the herbs are both part of the treatment. The words are not mere decorations; they are essential for efficacy. The ritual transformation of the herbs is an indispensable part of the technology. The idea of a ritual technology is very old in eastern African. Archaeologists have demonstrated that ritually relevant grasses, with symbolic meanings, were placed in ancient iron furnaces. If an archaeologist approaches the smelting process in a literally reductionist way, then the chemical properties of those grasses become relevant. But the technology of the ritual and the grass was a single technology; it was indissoluble. In a similar way, biochemists try to separate out the chemical properties of African herbs, but the words activating the herb are not meant merely as verbal markers of a technological act. The healer says, “May the bitterness of this herb remove the bitterness of the disease,” and the act of ritual speech is an integral part of the healing technology.⁹ It would not be correct to treat the herbs as the real source of healing power, and the words as symbolic supplement. As my mentor explained, the effect of the speech is to “transform” (*-hitua*) the herbs; the same word is used for transforming ore into iron, or clay into pottery.

Disease Causation

The identification of a disease entity, and with it a range of therapeutic possibilities, did not bring an end to the diagnostic process. If a therapy did not work, then further inquiries were undertaken, which often focused on the social or moral context of the illness. Mambazi Shemng’indo, for example, complained of *duazi* that had been going on for years, causing pain in her hip. She named the illness in different ways, depending on the social context she was emphasizing when thinking of the possible choice of a therapy. At one time, she described the condition afflicting her as *duazi ja teghea*—that is, *duazi* set as a trap by another person. Her condition, defined in terms of the symptoms and the way they were rooted in her body, was still *duazi*, but now additional factors of social context were relevant. Her husband, who was a healer, decided that he was simply not powerful enough to remove the trap, and so he ignored that, and treated only the *duazi*. “If [her legs] hurt her too much,” he said, “I give her herbal medicine from a medicine gourd. She

9. Bertram Mapunda, “An Archaeological View of the History and Variation of Iron Working in Southwestern Tanzania” (Ph.D. diss., University of Florida, Gainesville, 1995); Peter R. Schmidt, *Iron Technology in East Africa: Symbolism, Science, and Archaeology* (Bloomington: Indiana University Press, 1997); John Mitchell Watt and Maria Gerdina Breyer-Brandwijk, *The Medicinal and Poisonous Plants of Southern and Eastern Africa* (Edinburgh: E & S Livingstone, 1962).

uses it and then I'm taken aback to see that the pain recedes" (Shemng'indo, 24 June 1980).

In this case the condition was grounded in a malfunction of the organs (*duazi*), and yet, at the same time, the term *teghea* indicated that it was a consequence of human aggression. In other cases the social and "natural" factors were not intertwined, but rather ran on parallel tracks, as separate disease entities. When this happened, one could not tell simply from the symptom which of two (or more) diagnostic names was the correct one. A burning sensation on the skin, for example, could be caused by a kind of internal worm called *mshango wa chaghe* (the worm of *chaghe*), named after a kind of caterpillar (the *chaghe*) that causes a burning sensation if it touches the skin. Or it could be caused by a form of sorcery known as *ushinga wa kishiaghi*, named (once again) to describe a burning sensation; this time the name evoked the fire of the blacksmith (*mshiaghi*).

When sorcery explanations were used, they were not simply resorted to as a residual category. The argument is often made, in reference to African medicine, that if people feel confident that they know an effective natural therapy for a condition, they define the condition itself as something natural. Spiritual or social causes, according to this argument, are then attached to the unexplainable residue. But this is not the case. There were many examples of diseases that healers could not cure, which they defined as conditions that "just happened," without a moral or social cause. In 1979–80 a number of patients were suffering from the itchiness and thickening skin that is characteristic of onchocerciasis. Patients and healers were all clear that this was a condition that just happened, and that would not respond to treatment. They knew that neither *mshango* medicines, nor treatments for sorcery, nor treatments at the hospital would work.

Diagnosis by Addition

It is difficult to understand the logic of diagnostic reasoning in Ghaambo because an academic audience in America, or Europe, or Africa, expects that each disease entity will somehow be linked to an underlying mechanism. The audience has learned to be open to unusual possibilities—that the mechanism might be physiological, or it might be supernatural. In either case the search for a single mechanism is a characteristic of diagnostic inquiry. To think in this way is to import into our interpretation an implicit image of the institutional arrangements of late-twentieth-century biomedicine: that in a normal clinical encounter the diagnostician tries to understand a "case"; that "cases" are constructed "with minimal social and personal characteristics and great physiological de-

tail”; and that a normal encounter, when it is successful—when it is not a “hard” case—names a disease entity that is itself linked to an identifiable mechanism.¹⁰ We all carry this image in our minds, even when we know that the easy cases (“syphilis,” as an infectious disease with a known pathogen) bear a more striking resemblance to hard ones (chronic fatigue syndrome) than we would care to acknowledge.¹¹ The encounter between a physician and a “case” and the need to link a sickness to a specific mechanism remain, even among those who would study the ecology of disease, or who would expand the notion of “mechanism” to consider psychological factors.¹²

Despite all the thoughtful measures taken by medical thinkers and practitioners, the narrowly defined clinical relationship between a physician and a “case” is played out every day in thousands of encounters. At its heart is a process of subtraction, in two senses. The first has to do with diagnostic possibilities: the physician starts with a differential diagnosis, and proceeds to rule out one possibility, and then another, and then another, until the possible mechanisms, ideally, are reduced to a single one.¹³ The second kind of subtraction is the filtering out of idiosyncratic information about the personality and social circumstances of the patient, and about the illness experience. Physicians struggle with these issues because idiosyncrasies make a difference in therapeutic outcomes. Two patients may both complain about abdominal pain, but their words do not mean the same thing: one has a high threshold for seeking

10. The quotation about “minimal personal characteristics” is from Byron J. Good and Mary-Jo DelVecchio Good, “‘Learning Medicine’: The Constructing of Medical Knowledge at Harvard Medical School,” in *Knowledge, Power, and Practice: The Anthropology of Medicine in Everyday Life*, ed. Shirley Lindenbaum and Margaret Lock (Berkeley: University of California Press, 1993), pp. 81–107, quotation on p. 94. On the comparative weight of reductionism in biomedicine, see Arthur Kleinman, “What Is Specific to Western Medicine?” in *Companion Encyclopedia of the History of Medicine*, vol. 1, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993), pp. 15–23.

11. On the cultural construction of syphilis, see Ludwik Fleck, *Genesis and Development of a Scientific Fact*, ed. Thaddeus J. Trenn and Robert K. Merton, trans. Fred Bradley and Thaddeus J. Trenn (Chicago: University of Chicago Press, 1979). On chronic fatigue syndrome, and more generally on the ambiguity of medical categories, see Robert A. Aronowitz, *Making Sense of Illness: Science, Society, and Disease* (Cambridge: Cambridge University Press, 1998).

12. On the attempts to retain holistic understandings alongside reductionism, see Charles Rosenberg, “Holism in Twentieth-Century Medicine,” in *Greater than the Parts: Holism in Biomedicine, 1920–1950*, ed. Christopher Lawrence and George Weisz (New York: Oxford University Press, 1998), pp. 335–55.

13. We can see this process, which is a powerful and a useful one, enshrined in the weekly clinicopathological exercises reported in the *New England Journal of Medicine*. See, for example, “Case 7-1998,” *New England J. Med.*, 1998, 338 (9): 603–10.

medical care and needs immediate attention; the other can be asked to wait while the condition develops. A patient may have the chest pains that suggest coronary disease, even though angiography results deny coronary disease; the physician must then make sense of the reality of pain in the absence of an underlying mechanism. Robert Aronowitz, who writes about these questions, asks: “Should the doctor-patient encounter always involve a personal, not just a disease diagnosis? Should the patient’s experience or the doctor’s test define disease?”¹⁴ Questions about the personal context of disease, and about the patient’s experience of illness, were at the center of the process in Ghaambo. Patients there worked in the opposite direction, by a process of addition: they explored the social and moral circumstances of an illness in ever-widening circles. Ghaambo’s illness narratives were extended reflections on the sick individual’s personal nature and social position.

Social Location of the Patient

It is clear that I am overemphasizing contrastive elements by giving greater emphasis to the medicine of patients when speaking about Ghaambo, and the medicine of physicians when speaking about the contemporary United States. After all, American patients also reflect on their life circumstances, and many seek therapies beyond the ones prescribed by their physicians.¹⁵ One difference, as we shall now see, is that people in Ghaambo had a much richer vocabulary with which to describe the social embeddedness of their suffering.

These narratives often took account of individual variation from one patient to another. They said that who a person is can determine whether she gets sick—whether an illness cause has any effect on her—and can determine also whether a particular therapy will be effective. A recurrent phrase, in many of the narratives, is *kuivana na mzighi*. *Mzighi* is a medicine, a healing substance. *Kuivana* is the reciprocal form of *kuiva*, “to hear”; it means “to hear one another,” or “to understand one another,” or “to agree with one another.” If the person and the medicine are in harmony with one another, if they “hear one another,” the patient will be

14. Aronowitz, *Making Sense* (n. 11), p. 7; see also pp. 2–5.

15. A study conducted in the United States in 1990 showed that the number of visits to providers of unconventional therapies was greater than the number of visits to primary care physicians nationwide. The amount spent on unconventional therapies was about equivalent to out-of-pocket expenses on all hospitalizations. Americans were more likely to use unconventional therapies if they were white, college educated, and with higher than average incomes. See David M. Eisenberg et al., “Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use,” *New England J. Med.*, 1993, 328 (4): 246–52.

cured. Salehe Mzonge, a man in his mid-seventies, was thinking in these terms when he described an illness his wife was experiencing:

Her head was hurting intensely. . . . First she used medicine from the village shop—*aspirin* and *chloroquine*. They didn't work. Second, she went to the hospital. Once again, they didn't work. Those tablets simply remained whole inside her stomach. (19 October 1979)

He was not questioning the efficacy of the medicines as medicines, but simply pointing out that they did not work for her.

Some techniques had the purpose of changing the relationship between the person and the medicine. A healer in training, for example, could aim at achieving a special relationship with a particular medicine. The model for this was the blood pact, which transformed the relationship between two people. In the usual form of the blood pact, the two partners would take an oath and seal it by eating a bit of one another's blood on a *nkungu* nut. The pact transformed the two bodies, so that violation of the terms of the oath would lead to death. When the model of the blood pact was extended to medicines, the healer (or a sick person) would undergo the blood pact with a powerful tree, or an herb, exchanging blood for sap. As the late Hatibu Hassani explained, the purpose is "to have your body transformed at the . . . tree" (20 April 1968). Even if the body is not initially "in agreement" with the tree, it is "transformed" (*-hitukwa*), so as to come into harmony with it.

The therapeutic effect of the medicine depended also on the quality of the relationship between healer and patient. Was it a caring one, or was it a wholly commodified transaction? Anna Ezekieli had experienced a chronic cough over many years, diagnosed by Elizabeth Karlin as asthma.¹⁶ Karlin noted that local herbal asthma medicines appeared to work well. Anna Ezekieli explained to me that back in her childhood days, in her home area, she was regularly given asthma medicine by a healer, and it had been completely effective. I asked why she had not taken similar medicines over all the years she had lived in her husband's village. She said, "[My original home in] Kwe Hangala is far. [The person who treated me,] Shekibinda, is the father of my childhood friend. It's as though he raised me, like my own father. Here [in this village where I feel myself to be a stranger] I just go to the shop and buy Cofta [a patent medicine]" (5 October 1979). The Cofta, needless to say, was not as effective as Shekibinda's medicines had been. It is possible to imagine that in a double-blind study, the herbs used by Shekibinda would be

16. Anna Ezekieli said that it was *duazi*. A more common term for the symptoms of asthma was *mpumu*.

more effective for asthma than the patent cough medicine. But Anna Ezekieli was not assessing material objects in this way; for her, the herbs were the material form of the healing relationship. In her view, the herbs without the relationship could not be effective, nor could the relationship without the herbs.

To say that social relationships mattered is not to speak about a generalized sense of belonging; it is to talk about very specific sets of ties, with relationships of descent at the center of them. A person's health or illness depended on her access to the spiritual, intellectual, and material resources of a group of relatives, living and dead. Some people discussed this in terms of *mpakanya*. This had several meanings. One was a condition that could be healed only through the ritual participation of a whole descent group. A second meaning (by metaphorical extension from the first) was a disease transmitted through lines of inheritance—one which might, in a different idiom, be called genetic. Salehe Shemnkande, an aged healer, invoked this metaphor:

The disease of *mpumu* [wheezing, labored breathing, cough; most similar to asthma] does not spread from person to person in an infectious way. *Mpumu* is like *mpakanya*. It does not grasp a person if there is no forebear or relative of that person who has *mpumu*. Or if *lumo* [a disease of the stomach] affects a person, then you need to ask very carefully, and you will be told that his father, or his *mindughu* [brother or agnatic cousin] by the name of so-and-so is also affected by it. *Lumo* is not a usual kind of disease of the stomach, not at all. If a person has *lumo*, his [or her] stomach hurts, and he wants food that is very dry. He doesn't eat much. He eats just a bit—dry things that are roasted [rather than boiled]. He eats foods that are hard. *Lumo* is cured regularly in the hospital. (14 July 1980)

Descent, in this patrilineal society, is traced only through male links, and so the healer emphasized agnation in this statement, although diseases that passed from generation to generation through women could also be called *mpakanya*.

In days when ancestor sacrifice was still practiced (or among the few people who still practiced it in the late 1970s), some illnesses were seen as being caused by the ancestors. But even the most religious Muslims, or the most faithful Christians, still saw their fates as being tied up, in some way, to their dead fathers, or to their fathers' fathers, although they might pay their respects without an elaborate ritual. The *mpakanya* ritual was the most formal of these practices, but it was rare. Mzee Kihingo, who organized a performance of this ritual late in 1979, described its significance:

The ritual of *mpakanya* is one that must be performed with the participation of the whole of my lineage [*ukoo*]. I'll collect money from all the members, but if they don't pay, I'll pay myself. [Kihingo was by far the wealthiest of them.] Now, tomorrow, please come with the doctor, so that she can examine me. But if I don't perform the ritual of *mpakanya*, even the medicines of the hospital will have no effect. If I perform the ritual, then afterward the hospital medicines will bring an end to the weakness of my body in two days, or three. [Several days later, after the ritual had been performed, Kihingo spoke again:] [*Mpakanya*] is something that lays hold of a whole lineage. The illness affects this person, and this person, and this person. . . . There is *mpakanya* of *duazi*. Epilepsy can be an *mpakanya* also. . . . If a young woman is taken in marriage to that place over there, the *mpakanya* follows.

Once again we see that the therapeutic process worked by addition. Kihingo did not want to narrow down to a single cause—to find out whether his illness was grounded in nature or in the ancestors. He wanted to deal with layers of causes, to treat the condition of the lineage so that the hospital medicine would become effective: “If I perform the ritual, then afterward the hospital medicines will bring an end to the weakness of my body.” Kihingo knew that hospital medicines have their own logic, but he knew also that they would work only if they were grounded in the logic of social relations. Physiological conditions and social or moral relations became intertwined, so that the cause of the patient's condition could not be reduced to an explanation in one or the other domain.

In this world, each individual defined her own therapeutic universe, but not under conditions of her own making. A man's ability to heal himself depended not only on the effects of inherited disease, or the malign or benign influence of a dead forebear, but also on wealth or poverty in material or therapeutic resources, whether inherited or acquired individually. Mzee Kihingo could insist on the performance of the *mpakanya* ritual because he was relatively senior among his relatives, and because he was wealthy and could afford to bear the costs of the ritual if some of his relatives were unable to pay. A poorer person could find a less expensive (but perhaps no less efficacious) way to heal his network of relations, but some people (usually women) felt themselves cut loose, at a loss, knowing that the healing techniques existed that would make them whole, but knowing also that these were out of reach. One way a person could talk about this was to say that she was being sought out, or followed after, or pursued by an *mfuko* (pl. *mifuko*), a healer's medicine bag. This was an idiom in which a woman could speak about social deprivation as a cause of illness.

The *mfuko* was an emblem of lineage continuity, and also of continuity in the capacity to preserve life within the group. The basket filled with healing objects was passed from generation to generation so that its heir, usually a senior male, could use the objects to heal himself and heal others. He stood as a mediator between the ancestors and their living descendants. By the postcolonial period, of course, people had made varied religious choices, with implications for how they dealt with relations to ancestors. Some women were claiming, in 1979–81, that the heirs to *mfuko* were not playing their proper roles—not healing and nurturing their relatives. Each of these women, meanwhile, felt that if she could take charge of the *mfuko*, she would be able to heal herself and others. But in the language for saying this, the *mfuko* itself was described as exercising volition. It was not only the woman who wished to take charge of the medicine basket; it was the medicine basket, as the capacity of kinsfolk to heal themselves, that wished her to take charge. The *mfuko* was following her. By using the healing objects in their material form she would change her relationship to the *mfuko* and at the same time change the way her body was situated in a web of social relations. Only through an action in which the social and the material were fused was it possible for her to be cured.

Older women told some of the most touching, affecting narratives about medicines beyond reach, about life circumstances shaping health. An elderly woman named Mangoda Selemani spoke many times, over a period of a year, about the *mfuko* that eluded her, and that she needed if she were to end her suffering. The medicines in question had been acquired by Mangoda's mother; they were from the Indian Ocean coast, and a book (presumably in Arabic script) was the most important element. Mangoda had been initiated into the use of the medicine, but her brother was given the book, because he was a man, and it was for this reason that she continued to suffer ill health. A similar story was told by Asha Abedi:

I feel weak, and my back aches and my legs hurt, and I suffer from dizziness. . . . I use medicine for the *jini* spirit with which I was born, within my lineage. My father isn't around any more. It's my older brothers who have the medicine bag, but not one of them can master it. That's why my sickness is still with me. I've asked for the medicine bag, so that it can become mine, but there is no one who has mastered it adequately so that it can be passed on to me. The medicine bag wants me, but it is combining with other diseases in the body, like *shafura* [hookworm, or a condition with similar symptoms]. (28 November 1979, text 3)

What is important, once again, is that Asha's illness had more than one cause, and the causes were intertwined with one another—the first embedded in her relations with her dead father and with her brothers, and the second organic. The two were not separable. The full cure depended on knowledge and on therapeutic objects that did not float free, available for the picking. It depended on resources that could only come to the patient through people who exercised intellectual and ritual ownership. The healing knowledge was socially composed knowledge, and Asha Abedi did not have the social resources to complete the process of composition.

If we return to the question with which this paper began, of assessing the logic and efficacy of local forms of healing, we must take care to know what the condition is that is being cured. Does it make sense, when assessing Ghaambo's healing, to say that the condition for which Asha Abedi wished to be treated was hookworm? Or should we say that the relevant condition was social marginality? The answer to the question is made more complicated by the fact that she did not separate the two conditions in this way, and she expected a course of therapeutic action to address the whole of her condition.

Personal Choice and Efficacy: The *Jini*

Both the inherited diseases of *mpakanya* and the inherited therapies of the *mfuko* placed an emphasis on descent—on the way an individual was located in a web of relationships among people descended from a common forebear. These definitions of the social embeddedness of illness existed alongside others weighted more heavily toward individual variability and choice, and the individual's own intellectual understanding. This is especially clear in the treatment of *jini* illnesses. The word *jini* (plural *majini*) is derived from the Arabic *jinnī*. It was used in Ghaambo in 1979–80 with a wide range of possible references: a nature spirit, or a *jinnī* as described in the Quran, or an inherent but externalized part of one's own self—an alter ego—or an object that could be sent to harm others after it had been endowed with power through sorcery, or any one of a number of other definitions. One's relationship to the world of *majini* shaped the illness experience, but each person defined *majini* in his or her own way, and the extent to which *majini* had the capacity to cause or cure illness depended in part on the position taken by the sick person. How you situated yourself in the world of *majini* thus determined the relative efficacy of one or another therapy. Here is one explanation of *majini*, as given by Hassani Asumani:

HA: If you enthrone a *jini*, then in the end you will be forced to find medicine to treat it. Those who experience illness, or weakness, did not just get it from the spontaneous action of a *jini*. It only happens if your ancestors paid respects to the *majini*.

SF: Did your ancestors pay respects to the *majini*?

HA: Among my ancestors there were those who honored *majini*. (11 April 1980)

The clearest point made by Hassani Asumani—that a *jini* has the power to cause illness only if you yourself give it the power—is followed by an ambiguous statement about the relative weight that ought to be given to individual identity as opposed to shared descent. You honor *majini* because your forebears have done so; Hassani Asumani's forebears had done so; yet he did not honor *majini* himself.

The unresolved contradictions in this statement give a hint of the rich descriptive possibilities of the language of *majini*. A person might, at one moment, speak about the *jini* as a marker of her individuality—of her own special personality. That same person might, at another moment, speak about the *jini* as a way of describing the kinship constraints limiting everything he does, causing illness and blocking cure. The language of *majini* was one in which it was possible to reflect on the web of relationships and the personal illness experience, all at the same time.

For some of the people who saw the *jini* as an alter ego, the effectiveness of therapy depended not on your relationship to the healer's medicine, but rather on the relationship between your *jini* and his:

A medicine man is able to heal you if you agree [*-ivana*] with that person—with his *jini*. If you wake up the following morning and you're feeling just fine, well then your *jini* and hers are in harmony. (Hamisi Makonge, 15 October 1979)

If we read (or hear) the statements by different individuals in Ghaambo, then it becomes clear that people disagreed with one another not just on how far they would permit *majini* to enter their lives, but on whether *majini* were a legitimate concern at all, or a lot of nonsense. One woman, who saw *majini* as unproblematic, and as central to her state of health or illness, said:

My problem, you know, is that my whole body feels as though it's burning, and once it climbs through my body I find it difficult even to hear. It's that *jini* which is making things bitter for me; it still doesn't want to give me wholeness. When it wishes, then the illness will stop. (Mangoda Selemani, 26 July 1980, text 6)

Others dismissed this view as ridiculous. The following statement was made by a nominally Muslim man in his late fifties, who thought there was nothing sillier than the idea of *majini*:

Whoever talks about *jini* I know has a nail pushed to the side [i.e., a screw loose]. It is normal to have intellect times twelve; whoever talks about *jini* is missing one, or perhaps two. Shaaban Robert [the Swahili poet] said, "To give a *sheitani* a ring [*pete*] is to desire its presence." (Bakari Shelukindo, 13 November 1979)

Another view, held by a local Lutheran pastor, accepted the existence of *majini* but argued that they had no hold on Christians:

Majini exist; they are Satan; but they are unable to harm a Christian. The day you enter into the Christian religion, the *majini* are forced to stop bothering you. The *majini* are upset at the loss, but powerless against Christians. Many people have illnesses caused by *majini*, but are cured once they come to church.¹⁷

The pastor did not challenge the existence of *majini*, but told potential converts that the way to cure an illness caused by a *jini* was by converting to Christianity.

Uncertainty and Skepticism

Jini was a broad and contested category, with a range of meanings and uses which had been growing over the whole of the preceding century, since before the colonial period began. The range of disagreement and of competing understandings was wide on this subject. To say this, however, is not to imply that other ideas about health and the body were uncontested. Even though a great many people consulted diviners on an everyday basis, and even though divination was both ancient in the region and relatively stable, it too was a subject of intense debate. Hamisi Makonge, who was a seventy-five-year-old nominal Muslim with no formal education, was a thoroughgoing skeptic about the validity of divination:

I did not go to a diviner [for this illness]. Divination is useless; it is mutual deception without any point. Some said that my illness was caused by *mashai* [medicine left in the path, but not aimed specifically at the person who ultimately suffers]. When I thought about it, I saw that was nonsense. Now I've given up [all that *mashai* stuff]. I am just using [herbal] medicine of *mashangango* [that is, of *shango*]. (15 October 1979)

17. Daniel Ndagila, 13 March 1980. This quotation was not recorded verbatim at the time; it was part of a conversation during which it seemed inappropriate for me to take notes. I made notes, based on memory, the same day.

Skeptical language seems to have been characteristic of the world of medicine in Ghaambo and in the Shambaa-speaking region as a whole, and perhaps characteristic of a world in which many diverse therapies coexisted. It is clear that neither the openness of the therapeutic universe, nor the skeptical attitude toward healing technologies, was newly introduced in the twentieth century. A common late-nineteenth-century proverb declared: “Lies and deception, that’s medicine” [*Hufyohufyo ne ughanga*].¹⁸ If we think about the many-layered process of inquiry into the body and idiosyncratic personalities, and into human caring and human aggression, we can see how unlikely it is that people achieved easy certainty about cause and effect in the diagnosis of illness.

The achievement of certainty was made all the more difficult because the same human influences that might have caused the illness (in cases of aggression) could also derange the process of diagnostic inquiry. A person who attacked another could also use medicines to impede the therapeutic process. There was the case, for example, of Chalesi Sangoda, who could not understand why his wife thought she was pregnant when the government clinic said that she was not. Here is his account:

CS: My wife, beginning in February, began to look as though she was pregnant. First she went to the government clinic. She was told, “You’re not pregnant.” She took away some medicine with her. . . . Just recently I went for divination at Kwe Ughogho, at Nyange Halimasi’s homestead. It cost a shilling, and I myself was the one who went. At that point I trusted that she was not pregnant. The one who showed me that she was pregnant was that diviner. But he told me that there was also *ushinga* [a kind of sorcery]. There was a *kisimo*. Last week I took her to see a healer [here in the village]—Kimea Lukindo. Right now she feels the baby moving inside. . . .

SF: What is *kisimo*?

CS: *Kisimo* is medicine to confuse a person so that he (or she) should not want to seek treatment. She should not be treated. (1 November 1979)

Some time later, she had a healthy baby. In Chalesi’s account, the act of aggression which caused the pregnancy to be problematic was also, at the same time, an attack on the diagnostic process and on the efficacy of therapy. The presence of aggression made it difficult to sort out a proper course of action. A second example of this was *shakiizi*, a variety of sorcery which had the capacity to disorder the intelligence of the person under attack. When this was used, sorcery was simultaneously the cause of a disease and an obstacle to its proper treatment. The interference in the therapeutic process, in these cases, bears a rough resemblance to the

18. Steven Feierman, *Peasant Intellectuals: Anthropology and History in Tanzania* (Madison: University of Wisconsin Press, 1990), pp. 102–5.

unfortunate influence of social positionality in cases where women were pursued by the family medicine bag, yet remained just beyond its reach. In both sets of cases the social factors that were implicated in causing a condition became crucial, as obstacles, in the process of diagnosis and therapy.

Given the complexity of illness causation and the contested nature of diagnosis, it may seem as though it was impossible for patients or healers to make judgments about the efficacy of one or another therapeutic intervention. In fact, observations of therapeutic efficacy were often quite careful. They depended on judgments about the course of a particular illness as it unfolded through time. Healers and patients reflected on how long a period needed to pass between the time of a therapeutic intervention and the time when that therapy had definitively succeeded or failed. As Salehe Shemnkande, one of the senior healers in Ghaambo, explained, "If you treat something, then the day after tomorrow the person ought to experience a perceptible improvement. But if you keep on treating someone for months, that's not right" (3 April 1980).

When Salehe supervised the treatment of his own family members he observed changes in symptoms over time, and also how the symptoms responded to therapeutic interventions. There was, for example, the case of his one-and-a-half-year-old son Juma:

He had sores that looked like scabies but were different from scabies, because there was fluid on them. First we tried medicine for *ududui* [a skin condition?]. We applied medicine to the sores. And also we applied medicine for *shinga* [a kind of sorcery]. After a period I brought that to a conclusion. But then it swelled up and we went to have it lanced by a doctor at the hospital, but with no medicine to rub on the surface afterward. It was Dr. Little-Beard [nickname of an American volunteer]. That was last year. But just this week it returned. I went back to the measures I know. It's the sorcery of *ushinga wa kiviza* that makes trouble of this kind. First I use medicines that are applied to the skin. This morning I opened the sores with a needle. Pus came out. Once it is healed I will perform a ritual bringing the treatment to an end. (27 November 1979)

Salehe Shemnkande was recognizing continuities in the succession of skin conditions, but was also defining several discrete conditions, each with its own time horizon. Dr. Little-Beard's treatment was successful, its efficaciousness unquestioned. But then, when the condition recurred months later, it was time to ask new questions about the possible role of human relations. Even then, however, the father-as-healer addressed the symptoms, draining the sores and applying medicines topically.

It is important to note that while Salehe Shemnkande was himself a so-called traditional healer, on whom many others in Ghaambo would rely

for treatment, he had no hesitation in taking his son to the hospital for treatment. While the world of Ghaambo, as seen from the hospital, was one in which competing technologies were at play, Salehe's world was one in which a father's care for his son was more important than the particular technology. Sometimes that care came through the administration of family medicines, and sometimes it came through the payment of hospital fees.

Even for others, not in Salehe's immediate household, the fact that his healing style was that of a caring father was important for their judgment of the efficacy of his medicines. As Halima Rajabu said, "It is the older healers, men who treat us here at home, who help us" (6 February 1980). A telling distinction was made, in this therapeutic universe, between healers who "help" (*-ambiza*) and those out to make their way in the world of commodities. Salehe Kibindo refused the offer of medicine from men who were visiting from the village of Funta because "I can see that they're dying to get their hands on some money. They're simply into a game of deception" (1 November 79). Salehe Shemnkande himself argued that the biggest division among healers was between those who inherited medicines from their fathers and used them to help, and others who bought medicines but then sought a return on the investment. Even those who inherited medicine needed to keep on learning, he said: "New things come up" (3 April 1980, p. 16). But the central distinction, as he saw it, was between caring and commodification.

In terms of the contrast being explored in this paper, between scientific medicine and its institutional arrangements on the one hand, and the medicine of Ghaambo on the other, the concern for caring as opposed to commodification might seem, at the present moment in world history, to be universal in its distribution. American patients also want physicians who care, and American medical students struggle to balance the technical requirements of their new profession with their desire to be caring physicians. But in Ghaambo, as we have seen, reasoning about caring was at the heart of technology, in a form that is not institutionalized in American biomedicine. Anna Ezekieli, who was treated by the father of her childhood friend, knew that the only medicine that would be effective for her asthmatic cough was one in which the healer who "owned" the effective herbs was also caring and paternal. She judged this therapy as a social-material act, and knew that it needed to succeed on both counts in order to be efficacious. Caring, in this case, was not something separate from healing technology, as it would be to most American patients—an attractive, morally desirable but technologically unnecessary quality. It was a necessary part of healing technology.

It would be incorrect, however, to say that the efficacy of therapies was always judged on this moral and social basis in Ghaambo. In the case of the simplest therapies—for *shango*, for example—we have seen that herbs as material objects were thought to have a direct effect on the body-as-mechanism. And even in more complex therapies—for *duazi* as treated by healers, or for labored breathing treated as an *mpakanya*—people saw the herbs as playing a real role. But in these latter cases the herbs could be efficacious only within a socially defined therapeutic action, addressed with ritual speech, or administered in a family ritual.

It is both fascinating and difficult to grasp that a material action can at the same time be a symbolic and a social one, and that when this happens, efficacy cannot be judged on narrowly material grounds. Efficacy, as we have seen, can be defined in terms of the way a therapeutic act leads the patient's personality to mesh with a medicine, or to mesh with the personality of the healer. Efficacy can also be defined in terms of the effect of an herbal remedy that changes the patient's position in a web of kinship relations. Questions about access to an *mfuko*, an inherited medicine basket, were at the same time questions about access to material goods or to socially relevant knowledge, ways of discussing social deprivation, and inquiries about physical symptoms. All of these elements came into play in judgments about efficacy. People were thus assessing therapies on very different bases from the ones assumed by scientists, although they were not excluding the possibility of those narrower forms of efficacy.

In a context where healing acts were complex interventions in social, moral, and material relations, the subject matter of the history of medicine must be defined broadly. If we were to write a history of how Ghaambo's therapeutic world changed under colonial rule, we would need to explore how every kind of relationship changed over those years—relations between fathers and sons, husbands and wives, sisters and sisters, lineage mates with one another. Increasing commodification of the economy would be a part of the story. So, too, would the history of the relationship between colonial labor demands and local kinship forms, for these interacted with health and illness, caring and aggression, satiety and hunger, in constituting a larger social framework.

Of particular relevance was a colonial economy structured so that almost all social costs—for care of the aged, the sick, and the young—were borne by networks of ordinary people living, for the most part, in the countryside. Villages like Ghaambo were the real source of colonial-period health insurance, old-age pensions, funding for developmental

disabilities, and a huge range of other needs.¹⁹ Relatives and neighbors provided (and still provide) nursing care and food for the sick, whether at home or in hospital, and also paid for the costs of healers and medicines. The weight of all these burdens shaped the process of diagnosis and treatment. The villager who reasoned from symptom to social relation, or who interpreted illness as a failure in family continuity, was speaking in terms relevant to the colonial context. So also was the patient who said that medicines failed because a commodified relationship with a healer had replaced a helping one. And so was the diviner who spoke of the damaging effects of aggression. The organization of care in the village, and the habit of placing social needs at the heart of diagnosis, were entirely appropriate, given the heaviness of the burden placed on village society in the colonial economy. In 1981, twenty years after national independence, villagers were still responsible, largely on their own, for the social safety net.

In this context, where local people themselves carried almost the whole weight of support for the sick and the weak, the quality of social support was crucial to the healing process. This is not the place for a rigorous assessment of the relationship between social support and therapeutic outcomes, but even without that assessment it seems likely that the quality of the patient's intimate social relations was important for health and survival. If that was the case, then local judgments of efficacy, in which the social and moral effects of a therapy were bound up with its other material effects, would have been salient in understanding why some people thrive and survive while others sicken and die.

Epilogue: Hospital Medicine

One of the colonial-period introductions was Bumbuli Hospital, built in stages by the Lutheran church, beginning in the 1920s. Later, mostly after national independence, came government dispensaries. Local forms of healing, which had been open to a wide range of influences even before colonial conquest, now interacted with medicine in a European style. The academic assessment of folk healing, with which this paper began, was paralleled by an ongoing discussion in Ghaambo about the uses of dispensary medicine, or hospital medicine, within a therapeutic world defined in local terms. The boundaries between medical traditions were of course porous, with bits of knowledge and practice moving in both directions. One very brief example must suffice. Cha Mzighi, the

19. See Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *Afr. Stud. Rev.*, 1985, nos. 2/3: 73–147, esp. pp. 93–105, 120–24.

healer to whom I apprenticed myself in 1968, saw himself as teaching me “Shambaa medicine,” “traditional medicine,” but European medical imagery cropped up, from time to time, in unmistakable ways. He once explained a disease called *mpahazi* in the following way:

A person’s jaw might swell up, or he might experience a sore throat, or for the neck to swell at the glands. Sometimes there are small bugs [*vidudu*] that bore into your teeth. It is the small bug of *mpahazi*. The small bugs come in with food. That’s why we brush our teeth. (22 April 1968)

The idea of very small disease-causing organisms is presumably borrowed from post-Pasteurian European medical language. But, if so, it was grafted onto related conceptions that originated locally. *Mpahazi* was listed by F. LangHeinrich, in his dictionary based on research during the early years of colonial presence, as “a tick, a relapsing fever tick,” and also as an abscess at a tooth, out of which pus can be drawn.²⁰ *Kidudu* (small bug) was not listed, but it is the diminutive of *dudu*, which was listed as a loanword (presumably from Swahili) meaning insect, vermin. A Swahili dictionary, based mostly on early colonial materials, lists *dudu* as meaning insect, or vermin, but then also (in one dialect of Swahili) as smallpox (“variole”).²¹ We have, then, an old set of conceptions linking insects and diseases, which then in the colonial period absorbed some elements of bacteriologic thinking about infectious disease.

There is not adequate space here for a full discussion of hospital medicine, but a brief account is necessary. When Ghaambo people spoke about the hospital in 1979–80, they occasionally mentioned the idea of small disease-causing organisms. More often they spoke about *vipimo*—instruments for making measurements. Authoritative reports about instrument measurements by hospital workers were useful in sorting out the social context of illness, because hospital skills were effective only with illnesses of God. Mhammedi Shemng’indo described a condition in which he felt dizzy, with darkness falling over his eyes, when he stood up suddenly. He went to the hospital, where he was examined by Dr. Little-Beard, who took his blood pressure and tried to reassure him that it was normal. According to Mhammedi’s account, “Dr. Little-Beard said the customary measure is 80, you are at 80. Then I became afraid” (20 September 1979). Having ruled out illnesses of God, he needed to think about a range of other possibilities.

20. F. LangHeinrich, *Schambala-Wörterbuch*, Abhandlungen des Hamburgischen Kolonialinstituts, vol. 43 (Hamburg: L. Friedrichsen, 1921), p. 320. LangHeinrich collected the words and definitions between 1894 and 1906.

21. Ch. Sacleux, *Dictionnaire Swahili-Français* (Paris: Institut d’Ethnologie, 1939), pp. 173–74.

The hospital was anomalous in its way of dealing with payment. Most healers accepted a nominal payment to undertake treatment, and asked for a substantial payment only once the patient was cured. The hospital demanded money up front whether the patient improved or not, and people sometimes expressed bitterness when a long and expensive treatment ended with no apparent improvement. This violated the rules of the moral economy. When separating caring healers from commodified ones, most people placed the hospital firmly on the commodified side of the divide. The question, I think, was not one of total cost, but of the pattern of payments, and of the fairness of payment without cure.

It is easy to imagine the response of health-care planners, for whom total cost is more important than pattern of payment, or the response of physicians who reassure patients in good faith, out of kindness, only to find that their reassurances provoke extreme anxiety. The people of Ghaambo, one could imagine them saying, were judging the hospital in ways it would prefer not to be judged; the local people did not understand its real goals. This, then, is the mirror image of a historical/ethnographic science that would judge Ghaambo's healing practices on the basis of a narrowly material logic, or would judge efficacy entirely on the basis of pharmacological tests.

We thus come full circle, to Evans-Pritchard, Horton, and Porter, and to the scientific comparison with which this paper began. The very existence of comparison creates pressure for clarity—for a page with two columns, listing Ghaambo's medicine on the one side and a variant of biomedicine on the other. In practice, the comparison is cloudy. The spiritual in Ghaambo's medicine is echoed in the spirituality of Lutheran missionary doctors at Bumbuli Hospital; the materialism of biomedicine finds its counterpart in herbal medicines for *shango*; the social is embedded in both, in diverse ways.

The act of comparing medical worlds begins from the assumption that medical worlds are separate, and yet the worlds of Ghaambo's medicine and of biomedicine impinge on one another continuously, and they do so in power-laden ways. Examples of this cropped up every day during the research, in the case of a man who was harshly criticized at the hospital for consulting traditional healers, or a mother who was asked to remove her baby's amulets before coming to clinic, or a grandmother told by clinic aides that she was ignorant and incompetent, because the baby she cared for did not thrive. Power relations appear in the documents of our own work. Therapies which counted as "traditional" appear much more frequently in my own notes of daily conversations than in those of Martin Msumari Shembago, who (in an earlier period, as village party clerk) had exhorted people to dig latrines and boil water. My own role was ambiguous,

as was Elizabeth Karlin's. I was a tall *mzungu* (a "European") who bantered in Shambaa proverbs and was at home with talk of *ushinga*, but who sought medical treatment for himself and his children at the hospital, and who might be worth cultivating if you wanted an introduction there.

Interactions between the two worlds continue to be power-laden today. The herbs of Ghaambo and its surrounding region are being packaged in standard doses by a local, newly created not-for-profit organization to treat the opportunistic infections of AIDS. The leaders of this organization include both Tanzanian and expatriate professionals. They adopt folk knowledge, but place it in an institutional frame which would be completely alien to Ghaambo's healers. The organization's workers use local knowledge of herbs but not of ritual speech; they treat each herb as a narrowly material object, and not as though it were embedded in a social relationship; and they create standardized forms of herbal medicines which would otherwise be variable in content. Ghaambo's people, for their part, impose their own order on the medicine of the hospital, especially on the organization of time in the therapeutic process. Local care-givers judge efficacy by seeing whether the patient has improved after a course of treatment, but their own definition of a treatment is different from the hospital's, for they expect extended treatments to be ritualized. Outpatient attendants at the hospital give drugs without ritual to be taken over extended time periods—for seven, or ten, or fourteen days. Local people, in many cases, consider the non-ritualized treatment to be complete after a day or two, at which time they judge efficacy. It is on this short-trial basis that outpatient medicines must fit into local treatment regimens.²² This pattern then determines what space the hospital and its medicines will occupy in Ghaambo's larger patterns of medical care.

The point, throughout this essay, has been that the efficacy of each therapeutic intervention must be judged within its appropriate social context, and yet the overlap, or intermingling, of therapeutic worlds shows that the contexts cannot be kept separate. Biomedicine is a part of Ghaambo; Ghaambo's herbs, and its judgments of efficacy, are a part of biomedicine. Despite this, we can speak about diverse social contexts within this interpenetrating global medical culture. The task of defining the contexts of efficacy is more difficult than we might have thought, for they cannot be described in terms of stark and immutable contrasts. And yet the existence of a global medical culture does not erase the distinctiveness of its local syntheses. In Ghaambo, we need to explore the characteristic local context if we are to have any possibility of interpreting local judgments of efficacy.

22. The description of this temporal pattern is based on the record of treatments in 1979–81; it is highly likely that the pattern remains the same today.