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viennese ethnomedicine newsletter

The Baobab *(Adansonia digitata)*

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Frontispiece: Mizimi ya Tanga - Spirits of Tanga

(Tinga-Tinga painting by Peter Martin)

The Baobab is a highly spiritual tree. It is thought to be inhabited by ancestors and ghosts. It is the place where traditional healers and witches are contacting these higher forces, asking advice from them. These Baobabs are animated by positive as well as negative forces.

The story of this picture is as follows:
The person leaning on the tree is a patient. He was doing business in town, rarely visiting his place of birth. Then his father died in the village but he didn't go to his funeral. When his mother died he behaved the same way. He was leading a bad life, drinking a lot and having women. The ghosts of his dead parents were very angry with him. They sent him bad wishes and after half a year he got sick. He got weaker every day and soon couldn't work and earn money any more. He had to go back to his village. His relatives sent him to two traditional healers. On the picture they are both conducting a ritual. They pray, sing and move their rattles. They call their ghosts and finally find the cause of the patient's sickness. As an amends the patient has to bring a black cat for sacrifice to reconcile his parents. When the patient was cured he remained in his village. (Interview: Sylvia Hinger)

Viennese Ethnomedicine Newsletter

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Editorial

Armin Prinz

Another newsletter? This was my reaction to the suggestion of our African students to publish regular news from our Department of Ethnomedicine. Actually the idea of a newsletter had been in our minds for a long time, but somehow it was never put into practice, partly due to lack of time, partly also because nobody really dared to plunge into it. But then the optimism especially of our Ph.D. students Mrs. Hwiada Abu Baker from Sudan and Mr. Edmund Kayombo from Tanzania, helped us to overcome our reservations towards this project. In spite of their contagious enthusiasm we could not convince ourselves to publish a monthly or at least bimonthly periodical, but we agreed to try to bring out a newsletter three times a year: in February, June and October.

As we felt that we needed internationally recognised supporters for our project as members of the editorial board we contacted Prof. Nina Etkin from the Department of Anthropology, University of Hawaii at Manoa, USA; Prof. Wolfgang G. Jilek, Chairman of the Transcultural Psychiatric Section of the World Psychiatric Association, Delta, B.C. Canada; Prof. Guy Mazars, President of the European Society of Ethnopharmacology, Strasbourg, France; and Prof. Jun Takeda from Saga University, Laboratory of Ecological Anthropology and Marine Ethnobiology, Japan. Fortunately they all agreed not only to join our editorial board but also to take active part in the production of our Newsletter.

From our own University we successfully invited Prof. Karl Holubar, Director of the Institute for the History of Medicine; Prof. Wolfgang Kubelka, Director of the Institute for Pharmacognosy; and Prof. Karl R. Wernhart, Institute for Social and Cultural Anthropology, to join our editorial board.

Our Newsletter is not meant to be a sophisticated scientific journal but rather a paper giving news from our Department. We want to give an overview of our field research - activities, of Ph.D. and M.A. thesises of our students, publications of members of our institution and we will inform about current events in the Department. The central part of each issue will be one or two short articles presenting results of our research projects. A section "letters from the field" will focus on personal experiences of field researchers - a topic which normally is not given space in scientific journals.

As until now we have no financial support for a professional publication we have to produce the Newsletter with the limited budget of our Institute. For the moment the distribution of this forum will therefore be reserved to friends, members of our Department and members of our Society of Ethnomedicine.
We are very grateful to the directors of the Vienna International Airport, Dr. Gerhard Kastelic and Dr. Franz Kotrba, for printing this issue.

At the end let me add a few words regarding the development of our institution. On 13th April 1993 the Department of Ethnomedicine was founded and installed as a part of the Institute for the History of Medicine by the Austrian Federal Minister of Science. I was appointed its head. Since then I have been working here, at first as a part time assistant, later on as professor. Only in February 1997 another part time assistant, Ruth Kutalek, joined the department.
Until now our Department is the only university institution dealing with Ethnomedicine and Medical Anthropology in all German speaking countries. During these last five years about 500 students have attended the regular lectures of our department. 11 M.A thesises have already been accepted , 11 Ph.D thesises are in progress, 8 research projects are under work or have already been concluded. At the moment we have one M.A. and three Ph.D students from Africa who were the driving force to bring this newsletter into being.

Who am I?

Edmund J. Kayombo

Why are you puzzled and frown when looking at me? I know your problem. Yes, you want to know my name and where I come from, isn't it? Just a moment, I shall introduce myself. I am a paper, and my name is Viennese Ethnomedicine Newsletter. I am from the Department of Ethnomedicine, Institute for the History of Medicine, University of Vienna, Austria. My main objective is to share the rich knowledge of ethnomedicine in the contemporary world with you.

My front page will vary according to the main theme of the issue. In this issue the Baobab tree is shown. The botanical name of this tree is Adansonia digitata, family of Bombacaceae. It is growing especially in Africa, Asia and Australia. It is one of the world's largest trees. A Baobab tree is about 40-60 ft (about 12 to 18 m) high, the trunk diameter may be up to 30 ft (9 m), and branches can spread out up to 30 ft. (9 m). The products derived from this tree include the edible pulp of the fruits, medicine, rubber, fertiliser, soap, etc. The wood is used for making canoes and musical instrument in some parts of Africa.

The Baobab tree is significant also from the religious and sociological points of view. In some ethnic groups it is believed to be the home of ancestral spirits. Hence, some people offer sacrifice to their ancestors under these trees. The Baobab tree is also used as a place for settling social conflicts, resolving disputes, proposing and discussing customary laws, and for social gatherings. In dry lands the Baobab tree also functions as a water reservoir. Because of its great usefulness, not only for the social life of the community, but also in the field of traditional medicine, I use this tree as my symbol for the first issue of Viennese Ethnomedicine Newsletter (VEN).

But what is ethnomedicine? There are various definitions of ethnomedicine (Logan 1996, Hughes 1968). Some of these definitions are static and specific to human beings. But ethnomedicine refers as well to illnesses of animals and plants. Thus, we need a dynamic operational definition which includes all these aspects. In the VEN, ethnomedicine refers to informations specific to a given culture that allow its members to diagnose and categorise illness and trauma, explain their cause, and seek appropriate therapies to restore a critically sick patient - who may be a human being or an animal or a plant - to health.

Traditional medicine (TM) is one of the components of ethnomedicine. But as for ethnomedicine, there are also various definitions for TM (WHO 1976, Koumar'e 1983, Hughes 1986). However, these definitions are rigid and do not show the full functioning of TM in a given community. It is therefore argued that we need a dynamic operational definition of TM which encompasses all activities involved in TM. Therefore, in this copy of VEN, the term TM refers to the sum total of practices, measures and procedures of all kinds, whether material or not, which from time immemorial until today enabled people to protect their communities against diseases, to alleviate suffering and to provide cure for human beings, animals and plants. Please, let us be friends and exchange our informations on this vast subject; and let us contribute our share to make the contemporary world understand the role and the importance of ethnomedicine.

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The Importance of the Unimportant Culture of Disease and the Wisdom of the Traditional Medical System

Hwiada Abu-Baker

Socio-cultural studies have provided us with rich literature on the diversity of beliefs and conceptions concerning the human body, the nature of disease or illness as opposed to well-being, the different meanings of the signs and symptoms of disease, and choices of remedy. Such data has challenged the epistemological foundation of cosmopolitan medicine which is narrow in its outlook of disease as caused by physical, chemical or anatomical changes in the body and is not shared by the different cultures. It moreover fails to provide satisfactory explanations of peoples' illnesses which in many cases extend to other domains outside the strictly physical one. This challenge necessitated studying other medical or healing systems (consisting of practices, illness and therapy concepts, and practitioners' roles in both western and non-western societies).

In the traditional system of knowledge nature and culture seem to be interwoven. Biology is not a destiny. To the contrary, it is a fact of nature which enters into the logic of every social system and every cultural ideology. Biology and culture are mutually-affecting spheres of reality (Whyle 1963). On the other hand, like all systems of healing, biomedicine depends on rigid scientific cultural products. Biomedical assumptions date back to the period of Enlightenment where two streams of thought dominated the scene which prepared the ground for a new dominant ideology. The first stream of thought was the tendency to separate superstition and reason where the latter could transcend the former through scientific explanations. The second stream was the emergence of positivism which emphasised collection of facts, observation and measurements as the foundation for knowledge. Weber's means-end rationality which was prevalent in society also extended to the health sphere. Moreover, the Cartesian dualism which separates body from mind, self form matter has also dominated western thought from the seventeenth century onward where the body is seen in parts, not as a whole. The functions of these parts (organs) resemble the dynamics of a machine (Hepburn 1988:60-1). This holistic approach towards illness probably unsatisfies my lumping of these rich systems under the label "non western" + healing systems. As for biomedicine or as sometimes referred to as "western" "cosmopolitan", "allopathic" or "modern" medical system, here I am referring to the medical system that was initiated and originated in North America and western Europe and now is being institutionalised and practised nearly world-wide.

According to the germ theory of disease, the body becomes dysfunctional when it is attacked by germs. This exclusive biological view of the body failed to take into consideration the cultural, social and psychological accounts of illness. The biological view of the body which is embodied in biomedicine rests on the following assumptions: The body is composed of organs and systems which have functional relationships; the body in normal condition is experienced in a similar way among persons of the same sex and the same age; the senses are universal; disease is universally experienced; separation of self from the body is empirically verifiable; the body is a neutral, objective and natural entity (Manning and Fabrega 1973:254-5).

Medicine is defined, according to the Stedman's Medical Dictionary as: 1. A drug. 2. The art of curing diseases; the science that treats disease in all its relations. 3. The study and treatment of general diseases or those affecting the internal parts of the body; it is distinguished from surgery. These definitions show that biomedical assumptions equate medicine with drug. Its central concern is not with the well-being of the individual, but with diseased bodies. Disease is defined as 1. Morbus, illness, sickness: and interruption, cessation, or disorder of body functions, systems or organs. A disease entity is usually characterised by at least two of these

criteria: a recognised etiologic agent (or agents), an identifiable group of signs and symptoms: consistent anatomical alterations. In this way, biomedicine deals with diseases (abnormalities in the structure and function of body organs and systems) and not illnesses (perception of sickness). Biomedicine engages in the treatment of biologic and psychophysiologic maladaptation in the body, whereas traditional healing systems are occupied with illness which represents personal, interpersonal and cultural reactions of disease or discomfort.

The Importance of the Unimportant

"Illness is culturally shaped in the essence that how we perceive, experience, and cope with disease is based on our explanations of sickness; explanations specific to the social positions we occupy and systems of meaning we employ" (Kleinman 1978:252). Therefore, in identifying the ailment of the body, biomedicine discards the phenomenological experience of the patient. On the other hand, traditional healing systems approach the body holistically where the body becomes inseparable from religion, politics, economics, the arts, aesthetics and morality. In this sense, social relation, cultural myths, moral considerations, symbolic meaning and personal feelings all determine the meaning of the body and its well-being. Unlike the biomedical system which explains the "how" of illness by focusing on pathological malfunctioning of the body, traditional healing systems render answers to the "why" of misfortune in searching the causes for illness in the social, natural and supernatural domains.

In traditional communities quite trivial items with no apparent general significance in our modern view can take on a different meaning when seen alongside the material drawn from other cultures (Agassi 1975). Symbols constitute a means by which continuity can be assured. The symbol does not change throughout time, however, it is usually adapted to cope with those aspects of the "flow" that do change in time.

Because our "reality" is culturally modelled, the "reality" of the indigenous people is given form and takes shape by the culture they live in. They can be in every bit as ethnocentric as we are. Their knowledge, perception of things and events are determined by that culture. This is why to a person in a pre-industrial, pre-capitalist world the cure of headache by swallowing an aspirin (given by an outsider from "our" world) is of the same nature as the cure of my or your headache by having a local shaman ritual. It is perceived as the same thing. One is the outsider's way, which might or might not control the ache and the other is the indigenous way which also might or might not control the pain.

Morsey (1993) by taking the case of villagers in an Egyptian village (pseudo named Fatiha) revealed that the functioning of the body is attributed to other factors but merely to its physical constitution. Although villagers regard the human body as a complex system of differentiated parts, they attribute general functions to relatively few named structures. The body is seen as a complex structure where parts are identified like the chest, the liver, kidney, gall bladder, spleen, stomach and intestines, muscles, bones and the reproductive system. Yet, the most important are the heart and head (Morsy 1993:85-6).

Moreover, the proper functioning of the body is not independent of its surrounding. For example, villagers affected by the agricultural surrounding, view the body as a plant where too much sun and too much moisture may cause its debility. Social dilemma and emotional trauma are seen to affect the conditions of the body. This is made evident in the semantics of illness where, for example, a person who suffers from a fit (a psychological state) associates that with the drainage of blood from the body. Furthermore, both psychological and social dispositions are described in terms of bodily metaphors so that a greedy, wicked man is described as "having a heart of rock" or a "black heart" (Morsy 1993:92-3).

For the people in Fatiha, illness is attributed to natural, supernatural and emotional causes. The natural causes of illness are linked to bad food, bad water, worms, insects, sunstroke, humidity and unsanitary living conditions. Excess in work, food and sex are believed to cause weakness of the body (Morsy 1993:94).

In addition, the body is seen as having effect on the natural environment and on social events.

For example, a woman's infertility during menstruation could be transmitted to plants which may wither away and die. Moreover, people's survival is often attributed to the inherent symbols to control nature. Symbols of fertility have a kind of particular power that people consider as capable of influencing the course of events. They become pivotal in the belief system of the people who rely intimately on their ability. Also, bodily substances and powers (like the evil eye) could affect social relations through the use of sorcery (ibid. 1993). Bodily excretions are not devoid of symbolic power. For example, nursing milk, a symbol of life, is recommended for barren women to help them become fertile. Therefore, body substances are regarded as symbolic of life-producing forces whereas their misuse may cause harm to both natural and social environments.

Such links between the body and its environment are depicted in Levi-Strauss' notes on Zinacantan, Mexico, where he states that: "Names for parts of the human body are replicated in the names for parts of houses and for parts of mountains. In the case of Zinacanteco house, the walls are called "stomach", the corners are called "ears", and the roof is called the "head". The purpose of the new house dedication ceremony is to provide a soul for the house just as a human body is provided a soul by the Ancestral Gods" (Levi-Strauss in Manning and Fabrega 1973:278).

Living In „Different Worlds"

The doctor/patient relationship in biomedicine is characterised as being unequal. There is a social gap between both patient and healer. The knowledge of the doctor is seen as superior and more authoritative than that of the patient. The doctor is only interested in medical information relevant to the case at hand. His interest in the patient is seen as interest in a medical case and not in the human being. Emotional statements are avoided in the discussion of illness. The patient's belief in supernatural or other causes are often ridiculed and not acknowledged as possible cause for illness. Even medical terminology separates the world of the patient from that of the doctor. As Manning and Fabrega state: "The patient experiences a stripping away of identities to those bearing only on the medical history. The language the physician conveys to the patient conveys him as an object, isolated from himself." (1973:276-7)

Moreover, the technologies used (such as plastic arteries and veins, television monitors, steel bones, X-rays… etc.) assist in alienating the patient from his own body and help in exercising control over the patient since these remedies or devices are controlled by the provider and not by the person for whom they had been provided for. On the other hand, in non-western healing system the patient-healer-relationship is very personal, informal and based on dialogue. Usually, the healer is not set apart from the rest of the community, but lives the same peasant life like the villagers. No special training is required to become a healer except that she must be of proper age (usually after the menopause when a woman generally is regarded as pure) and have knowledge of the commonly transmitted wisdom. The efficiency of the traditional healing system is depicted as resting in elements of trust, talk and touch. A trust relationship between patient and healer is established through the reputation of the healer or by reference.

The Bejalica in Central Serbia, for example, heal with talk and touch. In treating infected wounds they use sets of metaphors and imagery in communicating charms in such a form - different from ordinary speech - that they hypnotise the patient into an altered state. Such induction of trance can activate endorphins which may alleviate pain and produce calm. Moreover, touch is used in massaging the infected wound with home-made balm and brandy. Touch acts as the communicative mode which keeps the healing process intact. It forms a bond between patient and healer. Interpretations are given to explain the effectiveness of the Balkan folk healing traditions. Firstly, the correlation between the body and mind may influence the immune system which induces healing. Secondly, the use of images, metaphors, stress reduction and relaxation techniques, hypnosis, massage and therapeutic touch is seen as good psychotherapy. Thirdly, the patient is encouraged to control his own body which enhances self-esteem. Finally, beliefs can prove vital in the healing process (Kerewsky-Halpern 1985).

In the biomedical system, disease or illness is the sole responsibility of the patient. The patient is kept away from his fellow men both physically and socially. Foucault shows how in the middle ages western societies expelled mentally ill patients who were transferred on board the "ship of fools" and taken to unknown distant lands. This expulsion took on a different form in modern times by introducing hospitalisation.

Contrary to this, in alternative healing systems, relatives, friends, kin and neighbours become involved in the healing process. As shown by Janzen 1978 in Zaire, illness is regarded as the responsibility of the whole clan since the sufferer is but a symptom of his family's illness. Similarly, in Mayan ethnomedicine "all illnesses are closely tied to interpersonal changes and readings of the intentions of others: illness can be said to represent a medium for expressing the state of relations between men and gods" (Manning and Fabrega 1973:264). The curing-function is to resolve and mediate socially defined disequilibrium.

In traditional healing systems throughout the therapeutic process the identification and causation of illness and related forms of treatment are culturally mediated. It depends on the culturally expected behaviour who is labelled as ill or sick. The identification of the cause of illness depends on the patient's and the others' perception of illness. Whether an illness is attributed to natural, supernatural, social or emotional causes depends on the duration of the affliction, its physical and behavioural manifestations and the type of social and interpersonal relations surrounding the patient. Such negotiation of illness reality between the afflicted and his relatives and neighbours legitimises the afflicted persons "sick role" which releases the patient form his/her social roles as well as the choice of appropriate treatment (Morsy 1993).

The anthropology of healing contests that patients resort to different theories of illness in treating their ailment. One can safely argue that "all medical systems can, then, be conceived of as pluralistic structures in which cosmopolitan medicine is one component in competitive and complementary relationships to numerous "alternate therapies". The choice of treatment, as conducted by Morsy in her study of Fatiha, will depend on situationally determined judgement of illness states, personal relations between the afflicted person and the medical practitioner, the economic requirements of different therapeutic practices, and the social (in other settings cultural) identity of the sick person.

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Initiation of Traditional Healers: an Example from Tanzania

Edmund J. Kayombo

"…..the other *izinyanga* have gone astray. They have not eaten *impepo*. They were not initiated in a proper way. Why have they mistaken when the disease is evident?" (Henry Callaway 1991:26)

Abstract

Even though there is variation on how traditional healers (THs) are initiated in different communities, there are world wide some common elements of initiation. This paper presents two case studies of initiation of spiritual traditional healers from Waruguru and Wadigo tribes of Tanzania. It draws comparison of initiation of THs from other African countries and world wide to show the common elements during initiation. This paper raises three main issues. Firstly, if one traces the origins of spiritual healers in their line of birth, it is likely that either their parents or grand-parents were healers. Secondly, as opposite to the past, now it appears that some spiritual healers are being trained by experienced healers who were initiated in a similar manner and taught how to practice traditional medicine. Thirdly, the primary health care managers who aim to provide health care to all should also include spiritual healers, because they provide health care to many people. Emphasis should be put to refer cases which are beyond their control to formal health services. Furthermore, to educate THs on common causes of illnesses such as bad drinking water, lack of latrines and convince them of the importance of sending children for immunisation.

Key words

Tanzania, Initiation, Spiritual Healers, Primary Health Care

Introduction

In Tanzania there are various categories of traditional healers. However, the major ones are herbalists, herbalist ritualists, ritualist herbalists and spiritualists (Mshiu et al. 1982). Herbalists, ritualist herbalists and herbalist ritualists acquire their skills in traditional medicine by learning from practising healers (Green 1984:1072). Nonetheless, there is limited literature on how spiritualists are initiated. Is it through heritage? Or do they acquire their skills like the shaman healers in Siberia as reported by Eliade (1964:4), or the Washo Indians of Western United States of America as reported by Handelman (1967:427)? For what kind of illnesses are these healers competent and therefore able to provide health care to people; hence which illnesses ought to be the focus of primary health care (PHC) in order to improve the health for all by the year 2015? This paper attempts to answer the raised questions by presenting two case studies of spiritual healers in Tanzania.

Data and Methods

Out of 20 healers who were informally interviewed by the author in the Institute of Traditional Medicine (ITM), Muhimbili University College Tanzania, two had an interesting story on how they were initiated. One of them was Idd living in Dar-es-Salaam. He was a Mluguru by tribe, 32 years old, Muslim, having completed primary school, married and had three children. His wife also had completed primary school and worked at Muhimbili Medical Centre (MMC) as a ward attendant. The other healer was Abdalla from Tanga region. He was Mzigua by tribe, 55 years old, Muslim, married, completed primary four and was a Tanga regional publicity secretary of MAACO (Kampuni ya Madawa ya Asili). The author made appointments with them for in-depth interviews at their respective residences in Dar-Es-Salaam. During the interviews the information was collected by audio tape and note taking. The in-depth interview focused on:

a) how they were initiated;
b) beliefs and taboos of their medicine,
c) illnesses they claimed to be competent to offer health care for. The collected information was transcribed and analysed. The results were summarised and are presented below.

Case Studies

A Traditional Healer from Morogoro

Idd narrated the story of how he became a *mganga* (healer) as follows. Before becoming a *mganga* Idd worked in Dar-es-Salaam, as a technician in the military force , and he also had a small shop in which his young brother worked. Since his marriage his wife had always been ill; she tried treatments of all forms of medicines, but with only partial success. His young brother who was working in Idd's small shop also became ill, and died after two days. Idd left his job and worked in his shop. After two months he became ill too. He tried both traditional and modern medicines in Dar-es-Salaam with no success. He went to his parents at Matombo village in Morogoro region for further traditional therapy.
When he met his parents they took him to various healers in the region to determine the cause of the illness. From the divination it was claimed that his own and his wife's illness as well as his young brother's death were all a call for him by his grand parents to be a *mganga*. The parents were directed to another *mganga*, who could provide treatment and train him to be a *mganga* himself. As a patient he stayed with the *mganga* to whom his parents had sent him for three years under treatment. At the same time Idd was helped to learn about medicinal plants and how to identify, collect, prepare and dispense traditional medicine to patients. Emphasis was put on verbal formulas and management of supernatural forces which have been incorporated in traditional medicine.

When the treatment was finished Idd's ancestral spirits ordered the *mganga* through dreams to give Idd three *mikoba* of medicine (*mikoba* are bags which are sometimes used to store traditional medicine. *Mikoba* is plural and *mkoba* is singular). The names of the *mikoba* were: Nisume, Maseru and Kingaru.
i) Nisume was the *mkoba* from his maternal grandfather. This *mkoba* was to be used for treating patients who were invaded by any kind of *jin* (ghost) as well as for any form of witchcraft or sorcery.
ii)Maseru was the *mkoba* from the paternal grandfather. This *mkoba* was to be used for treating various illnesses and *kuosha nyota* (to grant a person luck in his day-to-day activities).
iii) Kingaru was the *mkoba* from his maternal uncle. The *mkoba* was to be used to protect all *mikoba* and supplement treatment to patients.
Idd had to follow several beliefs and taboos which were connected with the three *mikoba*; the most important ones were:
i) To be honest to his clients in the process of treatment.
ii) To offer sacrifice (to the ancestors) once or twice in a year or at any time when they requested such sacrifice.
iii) Before going to collect the medicinal plants he should abstain from sexual acts.
iv) When his wife was in her menstrual period she should not touch the *mikoba*.

When Idd was given the three *mikoba*, he worked first at his parents' home, and later on moved to Dar-es-Salaam to his wife who became his assistant. The wife divined while being in trance, whereas the husband dispensed medicine. The knowledge of the proper medicine in the treatment of various patients was acquired through dreams, vision and by divination. For at least five illnesses he claimed to be fully competent: all gynaecological problems, mental illnesses, stomach and head aches, convulsion and psychic discomforts.

A Traditional Healer from Tanga

The second healer, Abdalla, reported the story how he became a *mganga* as follows. His father had been a *mganga* and died in 1943. In 1951 Abdalla became very ill and wandered around in forests for three years. After a long struggle his brother Ali came to a healer who divined Abdalla's illness. The healer informed Ali that Abdalla's illness was a call for him to be a *mganga* from the spirit of their late father's *mkoba* which had been forgotten after the father's death. The healer who divined Abdalla's illness directed Ali to send Abdalla to another healer called Athman Abdalla at Mandela Maua village for treatment. Ali counter checked the divination with two more healers and got the confirmation of what had

been divined. After that Abdalla was sent to Athman Abdalla for treatment as well as for training. As a patient Abdalla was for three years under treatment. When he recovered Athman began to train Abdalla to be a *mganga* (healer) using his late father's *mkoba*. Athman started by instructing Abdalla about medicinal plants, and later taught him verbal formulas and how to control magical powers both supernatural and those made by man. Within three years he knew almost everything about how to practice traditional medicine using his late father's *mkoba*.

On the graduation day, a *kilinge* (form of an altar) was prepared where the new *mganga* would stand during the graduation. A *tunguri* (small calabash which contains the main medicine of the *mkoba*) was hidden about two hundred meters away. He (Abdalla) was told to find his *mtoto* (literally meaning child, but here meaning *tunguri*) before climbing the *kilinge*. Abdalla's relatives, among whom were also some waganga, began singing the songs of *tambiko* (sacrifice) and the spirit of the *mkoba* entered into him (almost being in trance). He began dancing according to the tune of the songs while looking for his *mtoto*. When he found his *mtoto* he raised it up and there was great joy. He climbed the *kilinge*. Sorghum and maize flour were thrown at him as a *tambiko* (offering) and blessing. Under the *kilinge* there were six *mikoba* of the waganga who were invited to witness Abdalla's graduation.

While at the *kilinge* he was told that from now onwards he was a healer and his name of *uganga* (official title as healer) was to be Mkwayu. Then he was informed about the beliefs and taboos of the *mikoba* which he had to follow. He reported that there were many regulations, but mentioned only three and these were:

i) Honour and trust other waganga.
ii) Do not have sexual relations with your clients.
iii) When your wife is in her menstrual period she should not touch the *mikoba*.

Like with the other *mganga*, the knowledge which enabled him to heal was again acquired through dreams, vision, divination and learning from other waganga (plural of *mganga*).He claimed to be competent in treating the following illnesses: gynaecological problems, social and psychological illnesses.

Discussion

In the initiation process of shaman healers, there is a prescribed cultural path that must be experienced by the selected candidate (Wood 1979:313). The frequently reported paths include repeated misfortune, persistence of an illness and showing certain signs in youth that one would later on practice TM. The two case studies presented in this paper, show that the candidates were chosen by the spirits of the *mkoba* or the ancestral spirits who caused them an acute illness which did not respond to any kind of remedies. Similar cases of initiation of this type of healers in Africa, have been documented by Prinz (1994:133), Meyer (1991:93), Callaway (1991 (1870):27-33) and Devisch (1991:113). Green et al. (1984:1072) and Devisch (1991:113) have cited another form of call, where a candidate is struck by unexplained misfortune such as infants' deaths, failure of crops, loss of properties etc. The acute illness and unexplained misfortune force the individual/relatives to go to various waganga for divination to determine the causes of illness/misfortune and possible remedies. Through divination it becomes known that it is a call from their ancestral spirits or the spirit of *mkoba*.

From the two cases presented, it appears that the *mganga* who finds out by divination that a candidate is to be a *mganga*, is different from the person who treats him/her. The diviner directs the patient to another *mganga* who is elected through divination. The *mganga* selected to treat and train the candidate had himself been initiated in a similar manner. Seclusion of the candidate from his/her normal social surrounding and his/her stay with the *mganga*, as shown in the two case studies presented, is as well reported by Devisch (1991:112-117) and Callaway (1991 (1870):27-33). However the two cases differ from Green et al.'s study in Swaziland (1984:1072) which has shown that the healer who divined the patient and who treated and trained him was the same person. But all studies reviewed show that the patient is secluded from his/her social surrounding while in treatment and training. The acute illness of the candidate and seclusion while under treatment, seem to give a feeling of being "reborn" or "transformed" on the part of the candidate, and are a preparation for his/her new role in the community. As argued by Ngubane (1981:363), while in seclusion a candidate has

to undergo various forms of abstinence and withdraw from society to avoid contacts with sources of 'pollution' such as deaths which occur in his usual social surrounding. The healer to be must acquire skills and powers to control supernatural and magical powers which afflict the health of a person and endanger social integration of the community.
Some of the illnesses which the two waganga interviewed claimed to cure would appear a result of stress which is now common in rural and urban settings (Bibeau 1997:247).
A similar observation has been made by Janzen (1978:101-113, 205). No wonder that the spirits of their *mikoba* or ancestral spirits seem to play a crucial role in the process of treatment. As shown by Callaway (1991 (1870):29) "O, you have come when I am alone. The spirits departed yesterday". Therefore, the effectiveness of the medicine for patients depends both on the THs' and patients' following the beliefs and taboos of medicine (Kayombo 1996:78). It is thus, that not only medicines have curative elements, as most scientists tend to think, but also the rituals involved. Scientists, who know the medicinal plants which the healers use, go to the forest and collect these plants. When they analyse them they find out that the medicinal plants contain none or very little active substances which might work against the disease, which the healer claims to treat with the given medicine.
That the candidate is trained by an experienced healer has been shown in the case study presented in this paper, and is also described by Prinz (1994:133) among the Azande and by Green (1984:1072) in Swaziland. This type of training seems to be a recent development and perhaps takes place only in the case of this type of healers. Previously healers were not trained (Janzen 1978:150-156, Ngubane 1981:363, Green et al 1984:1072). As pointed out, in the training for the candidates emphasis was on identification of medicinal plants and teaching of verbal formulas as well as on how to interpret visions and dreams.

If one traces the origins of these healers in their line of birth, one is likely to find out that either their parents or grand parents were waganga. Some of these candidates might have been approached with the request to accept the *mkoba* in heritage and yet resisted. Or at the point of death the parents or grandparents who were practising TM did not hand over the *mkoba* to any one. The spirit of *mkoba* or the ancestral spirits had been looking for some one in their birth line to inherit the *mkoba* and found these candidates to be potential.

Conclusion

Spiritual healers presented in the two case studies in this paper and those reviewed from other studies in Africa have similar characteristics as shamans in the process of initiation. As argued by Prinz (1994:133) all African healers are initiated after an acute illness. But I think we have to exclude herbalists, because their initiation appears to consist in knowing medicinal plants and how to use them. All in all, spiritual healers have an important role to play in providing treatment particularly in illnesses which result from stress. Stress may lead to physiological, psychological and social illnesses. PHC managers who aim at providing health to all, ought to study how spiritual healers provide health care and asses the outcome. The spiritual traditional healers provide health care to many people. Hence, there is a need of seminars on handling cases of illnesses. They should be obliged to refer cases which are beyond their control to formal health services. Furthermore THs should be informed about common causes of illnesses such as polluted drinking water, absence of latrines, and they should be convinced of the importance of sending children for immunisation. It has to be noted that more than 70% of the population of Africa make use of TM (Bichmann 1984:116) and some might also be going to spiritual healers.

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Field work Experience

The Field work experience column will be constantly present in the "Viennese Ethnomedicine Newsletter". It is mainly concerned with students' and scholars' field experiences, and how their encounters were meaningful, communicative or unacceptable, how in some way they were conservative, open, reflexive, friendly or hostile how the community members were reactive, interactive, welcoming or sometimes not at all responsive to some issues presented by the researchers. Through this column we hope to share your and our experiences in the field work.

Fieldwork with a Seereer-Healer in the Siin-Saalum-Region in Senegal

Fimela, June 1998

Dear friends and colleagues!

Asked to write a short letter about my fieldwork with the Seereer in Senegal, I did not know where to begin and what to choose.
Since I did not want to write about the raw material of my research work itself, I chose to write about one aspect of the relationship with "my" healer, Ndiom Faye, with whom I worked for the past six months. I do not feel ready yet to paint the portrait of his personality and life which will be the aim of my work.
I want to tell the story of the gifts I gave him during that time and which became the basis of our friendship and made our work possible. Every thing has its own little story and its justification, so this won't be just an enumeration of different items.
The first day I came to Ndiom he had recently suffered a serious asthma-attack. Questioning him on how

he treated himself, he showed us the prescription of a local bush-hospital for a cortisone-depot-injection. An oldtime favourite of modern medicine came to be my first gift for the traditional healer. He was laughing when he asked me if I could inject it myself. I preferred not to take a risk with the confidence that was just about to be established and I sent him to the local dispensary. At the price of 2490 CFA (ca. 50 öS) modern medicine helped to make the first step in approaching the healer.
After several visits I noticed that Ndiom was always short of plastic bags and paper to wrap up the medicinal plants - leaves, roots, barks in various forms and combinations - for the patients to take home. In Fimela I had quite a lot of these things and I brought him a whole sack of wrapping material. He was so happy about it that for every new patient he began searching for the right piece. He did it in such a noisy way that on the tape I had recorded of this day I heard only rsh-rsh-rsh. I decided not to give him any more plastic bags.
Several times Ndiom asked me to teach him how to read the clock. He had me sit right next to him and he wanted to learn the numbers in French. He repeated everything but did not seem to understand the meaning of the long and the short hand. From a trip to Dakar I brought along a silvery watch with big numbers. He was very happy, I had to fix it at his wrist and he proudly showed it to all of the family who almost died laughing because he does not even know how to read the clock. Since that day I never saw him again wearing the watch. I was a little puzzled till I saw his daughter who is at school in Fimela wearing the watch. Later, when one of his daughters-in-law bought a watch for herself, he said: "Only lazy people need a watch to look at during work!"
In May Sourva Sarr, our old landlord in Fimela, had a proposition for me: he wanted to sell his beloved and well fed young ram - named Achod after my friend who was visiting when the lamb was born. I was sure that he just wanted to make me, as the new owner, pay for the food; he had already told me the price of a sack. Without much bargaining I bought the beautiful animal and brought it to Ndiom a few days later. Sourva was a little surprised but agreed because he counted Ndiom among his friends since he had been made invulnerable by his knowledge.
Ndiom just loved the ram - he talks with animals in the same way as with people and everybody laughs about it. Achod got his place of honour with the stallion in the backyard of Ndiom's hut, the place where the patients do their ritual washing and where he himself offers for the "pangool" (spirits of the ancestors) on the pestles at the trunk of the sacred baobab. The first few days he tied the ram to the tree in the middle of the courtyard to make sure that every visitor should see him.
The greatest pleasure for Ndiom were alcoholic gifts. It was our "patarong" Prof. Prinz who gave him the first bottle of wine - "Val Pierre", acquired at the catholic mission in Fimela. From then onwards once in a while I brought him a bottle which he emptied in no time. Using his blue plasticcup he drank the wine as if he were drinking water. That made him very talkative and funny, forgetting headaches and sorrows, but soon after he became very tired. He would lounge on his bed until falling asleep in the middle of a sentence, when my questions became too annoying. I had to sit and wait until he had slept enough and was sober again. Giving him alcoholic beverages came to be a matter of conscience for me; I had the impression that his family was looking at me in a reproachful manner. To make up for that, I brought fresh fish every day and a big sack of rice once in a while.
Two times we made a trip to the interior of the country to visit Ndiom's brother in order to learn something about his family and childhood. As presents we brought wine and "Pastis" (anis-liquor); Ndiom began drinking with his old friends and a normal conversation became impossible. The third time we went without him and had a very interesting and fruitful talk with his brother.
When I got to know Ndiom and his manners better, I started bargaining. One day he complained of a severe headache, he just had to have his bottle of wine. I agreed fetching a bottle with the car on one condition: I wanted to take pictures of all steps of his diagnostic oracle. He had always refused because of the "pangool", but when he had got his bottle of "Val Pierre" and started drinking he imitated the whole oracle waiting even for my flash to recharge.
On the last day with him I brought three chickens, ingredients for cooking and a bottle of wine for a fine farewell-meal for the whole family. Cooking took its time; meanwhile Ndiom had emptied the bottle and slept like a stone in the middle of the courtyard on his mat. He was unable to get up for eating even though it was his favourite dish. Only when everybody was getting ready to take the pictures I had promised for a long time he got up and made everybody laugh when he openly embraced his two wives for the photograph.

To finish up there were bread, Cola-nuts and sweets for the children and not to forget two walnuts from Europe he had to crack.
The more scientific part of my research work will be published later on, but I hope today's letter will give a little foretaste.

With my best regards
Felicia Heidenreich

The Social Forum

Networking and Departmental News

New Scholars in the Department of Ethnomedicine

ÖAD (Österreichischer Akademischer Austauschdienst), Referat für Entwicklungszusammenarbeit, has funded two students to work on their Ph.D thesises at the Department of Ethnomedicine during the academic year 1997/1998: The two students are: Teshome Wondwosen from Ethiopia and Hwiada Abu Baker from the Sudan. The department congratulates the new students and wishes them all success in their work and research endeavours.

Afework Kassa has been granted a scholarship from ÖAD for a two-year's programme to get a master's degree in Medical Anthropology at the Department of Ethnomedicine. Congratulations to Afework.

The Department of Ethnomedicine is welcoming the return of Edmund Kayombo from his field-work in Tanzania where he spent six months in three administrative regions- Iringa, Mbeya, and Rukwa. The department wishes him again a lot of success in his research endeavours.

Activities of members in the Department

The Society of Ethnomedicine (AGEM) organised its 13th International Conference in the University of Munich, Anatomische Anstalt, from March 6.-8. 1998. The theme of the conference was "Therapeutic Concepts in Transcultural Comparison". The conference was interdisciplinary, highlighting the different scientific research areas of medicine, ethnology, psychology, pharmacology and sociology. Members of the Department of Ethnomedicine were vividly present in the different conference activities. The following papers were presented:

Afework Kassa: Traditional Method for Breast-Enlargement Used by Rural Girls in the Fitche District in Ethiopia.

Christine Binder-Fritz: Traditionelle Therapeutische Konzepte der Maori Neuseelands. (Traditional Therapeutic Concepts Among the Maori of New Zealand.)

Ruth Kutalek: Traditionelle Heiltherapien bei den Bena SW-Tansanias. (Traditional Healing Therapies Among the Bena of SW-Tanzania.)

Dagmar Eigner: Struktur und Dynamik schamanischer Heilrituale in Nepal. (Structure and Dynamics of Shamanic Healing Rituals in Nepal.)

Maria Michalitsch: Aspekte der Anwendung der Traditionellen Chinesischen Medizin (TCM) in Österreich. (Aspects of Practising Traditional Chinese Medicine in Austria.)

Armin Prinz headed several workshops in the conference and presented a paper as well:
"Kaza Basolo". Ein kulturgebundenes Syndrom bei den Azande im Nordwest-Kongo.
("Kaza Basolo". A Culture-Bound Syndrome Among the Azande of Northwest-Kongo.)

In general the conference offered unique insights into present-day research and therapy in transcultural comparison. The workshops offered many opportunities to gain practical experiences in "Ethnomedicine" as a field of research allied with other multi-disciplinary fields of social and natural sciences. Different members and specialised individuals in the area of medicine and ethnomedicine presented their most recent findings in different field areas in the world using interdisciplinary methodologies.

Guest-lectureship

In the next summer semester Margaret Lock from the McGill University of Montreal will be a guest professor in Vienna. She will be giving lectures at our Institute. Further information in the next issue of VEN.

Publications of the Department 1997

Prinz, Armin: "Kaza basolo". A Culture-Bound Syndrome Among the Azande of Central-Africa. In: The 6th International Symposium on Traditional Medicine in Toyama, Japan (1997). Proceedings of the Symposium. S117-125

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Kayombo, Edmund: The Missing Component in Family Planning in Tanzania. In: Gottschalk-Batschkus, Christine E.; Schuler, Judith; Iding, Doris (Hrsg.): Frauen und Gesundheit - Ethnomedizinische Perspektiven, Sonderband 11/1997, S133-140

Kayombo, Edmund: "*Tambiko*" as Healing Therapy in Tanzania. In: Madu, S.N.; Baguma, P.K.; Pritz, A.: Psychotherapy in Africa. First Investigations. World Council for Psychotherapy, Wien 1997, S 71-81

Kellner, Martin: „In allen Instrumenten liegt Nahrung für die Seele". Zur Bedeutung von Musik in der europäischen und arabischen Humoralmedizin. ("All instruments are nourishment for the soul". Music in the european and arabic humoral medicine) In: Curare. Vol. 20 (1997) 1

Lectures

Armin Prinz:
Introduction in Ethnomedicine (Summer semester 1999)
Nutritional Anthropology I (Winter semester 1997/98)
Nutritional Anthropology II (Winter semester 1998/99)
Seminary for Ethnomedicine (Winter semester 1998/99)
Seminary for M.A and Ph.D candidates (Summer semester 1999)

Ruth Kutalek:
Fieldwork in Ethnomedicine: Theory and Practice (Winter semester 1998/99)
Ethnopharmacology (Summer semester 1999)

Christine Binder-Fritz:
Gynaecology and birth from an ethnomedical perspective

Dagmar Eigner:
Ethnopsychotherapy

Bernhard Hadolt:
Medical Anthropology (Winter semester 1998/99)

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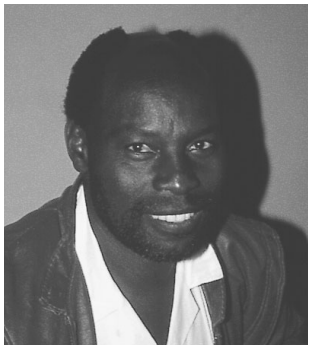
Felicia Heidenreich, M.D., researcher in our Department's project: "Traditional Medicine among the Seereer in Senegal" financed by the Austrian Fund for Scientific Research.



Edmund Kayombo, M.A. (demography), research fellow at the Institute for Traditional Medicine, Muhimbili University College, Dar es Salaam, Tanzania; Ph.D. student at our Department

Next Issue Preview
February 1999

Field report: The integration of traditional Maori medicine into the modern health care system of New Zealand. Christine Binder-Fritz

Photograph last page: Back to the roots! The traditional Maori face tatoo *(moko)* is a symbol of the present cultural revival in Aotearoa/New Zealand.

Submissions, announcements, reports or names to be added to the mailing list, should be sent to:

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Maori face tatoo – *moko*

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