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quondam ACADEMIA CAESAREO - REGIA IOSEPHINA 1785

department of ethnomedicine

Frontispiece

The painting of John Kilaka deals with the procurement irregularities concerning special laboratory devices – the so called CD4 counters. Bundled money is falling down from the sky onto an umbrella which prevents people receiving money for Aids treatment in the villages in Tanzania. Seated in the umbrella are fat men "eating" the money of the poor (see article by Rainer Brandl in this issue).

johnkilaka@yahoo.com

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Content

Submissions, announcements, reports or names to be added to the mailing list, should be sent to:
Editors, Viennese Ethnomedicine Newsletter, Institute for the History of Medicine, Centre for Public Health, Department of Ethnomedicine, Währinger Strasse 25, A-1090 Vienna, Austria
FAX: (++)43-1-42779634, e-mail: ruth.kutalek@meduniwien.ac.at
homepage: http://www.univie.ac.at/ethnomedicine

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A Case Behind the International AID(S) Business: Corruption Siphons AIDS Money

Rainer Brandl

The artist John Kilaka (see painting front page) reflects on the mounting evidence of procurement scandals at the Ministry of Health in Tanzania which allegedly granted a single supplier with exclusive rights to provide HIV/AIDS laboratory equipment for National AIDS Control Programmes. This led to a broad public discussion with several front-pages in the national Kiswahili and English Press. Kilaka shows through his painting that market monopolization and corruption are directly connected to the suffering of the people at the grass roots. Institutionalized human greed is interfering with the immediate needs of the downtrodden in the villages. These needs are: Best and affordable technologies and effective use of funds allocated for serving the health of the masses. The cry for life is opposed by international industries striving for market control and corrupt local elites struggling for financial gains.

During the last decade antiretroviral drugs ("AIDS drugs") have turned HIV/AIDS into a chronic disease as opposed to what once was regarded as a death sentence. Nevertheless, still only a minority of roughly one in six Africans who are in urgent need for treatment have access to these life saving drugs by December 2005 (UNAIDS 2006). At present many countries say that they want to scale up treatment and prevention rapidly leading to full access. The realization of the human right for treatment was again demanded by People Living with HIV/AIDS at the XVI International AIDS Conference (International Aids Conference 2006). Therefore a lot of equipments and tests are procured and the door for manipulation and corruption seems to be wide open.

The piece of Tinga Tinga art deals with the procurement irregularities concerning special laboratory devices – the so called CD4 counters – and John Kilaka specifically chooses one of the most dramatic cases within the procurement scandals. The issue was discussed and documented for several weeks in the country's English (The Citizen No. 511, This Day No. 174, No. 104) and Kiswahili (Rai No. 666, No. 667) press. The daily Tanzanian newspaper This Day (No. 174) reported on its front-page: "A Dar es Salaam businessman with exclusive rights to supply HIV test kits – at hiked prices – is behaving like a gagged man against press probes, This Day can reveal. Mr. Bharat Rajan, CEO of Biocare Health Products Limited, is currently directing all questions to the Ministry of Health as if it were part of his outfit. Mr. Rajan's firm currently supplies almost every equipment and reagents from a global fund to fight Aids, Tuberculosis and Malaria to the Ministry of Health and Social Welfare at fictitiously high prices … … Investigations by This Day have established that Rajan's Biocare has supplied the ministry with chemistry analyzers, hematology analyzers and FACS Count cd4 count machines which are said to be costly because they use expensive reagents."

CD4 counters are special flow cytometers and used all over the world as "gold standard" to determine the immune-status of HIV/AIDS patients by counting CD4 positive blood cells (also called T-helper lymphocytes). CD4 positive cells represent the backbone of the immune-system. The number of these cells slowly decreases in the HIV infected individual. To know the CD4 count of somebody who is HIV infected is an essential help in determining when to start and to monitor life saving treatment by antiretroviral drugs.
The brown box in Kilaka's painting with the letters "FACS" on it symbolizes a FACS Count (Fluorescence activated cell sorting) which is the brand name of Becton Dickinson's CD4 counter (BD Biosciences, USA) and obviously the favorite machine of the Ministry of Health of Tanzania. (Private Health Laboratory Board, August 2006; Rai No. 671; This Day No. 174).

Compared to more recently developed CD4 counters on the market, the FACS Count was

originally designed for the use in the highly sophisticated environment of clean laboratories in industrialized nations and not for the dusty health centre or outreach program in a developing country in order to closely serve the needy rural population. The FACS Count lacks an additional feature – the CD4 % of total lymphocytes necessary for the proper treatment of children below the age of 7 years (USAID 2006). This is especially important as the proportion of – due to mother-to-child-transmission – infected children is very high in the resource limited rural African setting with its matured and generalized HIV epidemics and the determination of the CD4% is also requested by the guidelines of the National AIDS Control Programme of Tanzania and by the World Health Organization (WHO 2006).

Although the lowest found list price of the FACS Count (USAID 2006) with 27.000 US$ is comparable to other products on the market; it was reported from different countries that the over the shelf prices were sometimes up to 4 times higher (Partec personal communication 2005, 2006). It is general knowledge that higher prices are found especially after decisions leading to market domination of a single product or after adding additional costs for freight, local distribution, warranty, service contracts or installation and training.

The FACS Count is a closed system, which means that only the pre-packed original reagents of the manufacturer can be used for this type of machine, which practically eliminates competition in the field of reagents for this technique and therefore national treatment programmes and Ministries of Health would depend on only one supplier.
As internationally often the case, the price of reagents and other consumables are very different depending on the market share, the level of regional competition, and the local price policy of companies. In some cases the prices for reagents are reportedly 3-25 times higher than those of other manufacturers or the announced minimum price. The Clinton Foundation says that its negotiations with manufacturers like Becton Dickinson have brought the test down to 5 dollars (Carter 2004), but currently in Zimbabwe the cost for one of Becton Dickinson's CD4 count is US$56 and is revised upward quarterly according to a scientific peer-reviewed publication of the University of Zimbabwe and Stanford University (Zijenah et al. 2006).

In John Kilaka's painting "The FACS Count" bundled money is falling down at an umbrella which covers the people in the villages. Seated in the umbrella are fat men eating good food and counting money which is channeled into their own pockets. Their pecuniary wealth seems to be financed through artificially high prices and cooperation contracts with local distributors (This Day No. 174) who are excluding other competitive high quality products from the national market. International funds and the country's tax funded budget are feeding some of the politicians, civil servants and so called experts, who eat rich meals and enjoy high quality life, while the rural, uniformed and poverty-stricken men, women and their children under the umbrella are cut off from their constitutional and human rights for proper health care, they are starving and they have no shelter. The smaller brown box on the table of the desperately weeping villagers with the letters "CYFLOW" on it, symbolizes a "CyFlow" which is the brand name of Partec's CD4 counter, developed and manufactured especially for the use in resource limited settings, while the same key technology is also in use for other applications in the US, Europe, Japan and the rest of the world (see Partec homepage).

The well working laboratory equipment is lying idle on the table as its use is blocked. The villagers cannot understand the rationale behind this as already they were perfectly served by the equipment (Partec personal communication 2005, 2006). The CyFlow has many advantages and therefore studies from different authors published in world's renowned scientific journals and from most reputable scientific groups – including co-operations with Boston Harvard School of Health (Imade et al. 2005), Stanford University (Zijenah 2006), and Center of Disease Control – CDC (Pattanapanyasat et al. 2005) as well as organizations like Doctors without Borders MSF (Fryland et al. 2006) propose the use of this product as one of the solutions to scale up life saving antiretroviral treatment in resource limited settings.
A conclusion of a very recent study says: "Although the purchasing price of FACS

Count and Cyflow counter are comparable (US$ 30 000 - 50 000), the FACS Count reagents are more expensive than those for the Cyflow. The Cyflow counter also has a high throughput and as many as 200 specimens can be run per day, making it ideal for use in Zimbabwe, a country with one of the highest prevalence of HIV globally. In conclusion, the Cyflow counter is as accurate as the FACS Count in enumerating absolute CD4+ T lymphocytes in the range 1-1200 cells/µL. Cyflow cytometry is relatively affordable, easy to use technology that is useful not only in identifying HIV seropositive individuals who require ART but also for monitoring immunologic responses to ART." (Zijenah 2006)

A CyFlow CD4 counter can run on a car battery or a solar panel and because of its robustness and portability it can be operated in a rural health centre or in a car by one trained person and its handling is rather simple. Mobile laboratories are already successfully used in Nigeria (Gede Foundation), in Benin ("action pro humanity"/government) and in Lesotho (UNDP). One CD4 test costs worldwide always the same and is at present the least expensive with only 1,75 Euro (2,5 Euro including cd4% per test) and according to the manufacturer in the year 2006 approximately 1.1 million CD4 tests will be distributed worldwide. According to the manufacturer exactly 346 Partec CyFlow devices have been placed in more than 30 African and 10 Asian countries within the past 3,5 years" (Partec personal communication 2005, 2006). Nigeria has decided to use the CyFlow as a national reference method and placed already more than 100 CyFlow units. Partec CD4 counters were mainly ordered by small programmes of local and international NGOs and faith based hospitals but also by some UN programmes (UNICEF, WHO, UNDP). The cost for the Cyflow-SL3 which can directly do the additional feature of CD4% (in order to facilitate treatment of children below 7 years of age) is worldwide always the same with 20.850 Euro and therefore even a bit less than the lowest international price found for a FACS Count (which is lacking to do a direct CD4% of total lymphocytes and therefore cannot directly serve the HIV positive children). This over-the-counter price includes a starter kit containing several hundreds of tests, consumables, an uninterruptible power supply, and at least a one year warranty. Accordinbg to Partec, compared to the FACS Count, the cost for service contracts and consumables are offered at starting prices three times lower than reported for the BD FACS Count.

In December 2005 a price guarantee of 10 years was offered to the Ministry of Health in Tanzania (Partec personal communication 2005, 2006). However, numerous letters and offers from the company to co-operate with the national programmes and to develop even better and less expensive ways of CD4 counting never got any response. Instead of answering theses letters, the official Tanzania prohibited the import and use of the CyFlow (Rai No. 671, Private Health Laboratory board 2006) saying that its technical performance is poor and the test results are unreliable, following findings of a research which was reportedly done by Muhimbili University of Health. For unknown reasons this research was never published and requests to present the methods and data were never answered.

The former Minister of Health recently said in a media interview (Rai No. 674) that she had advised her civil servants and university professors last year to purchase various types of machines in order to make the country more independent and to keep the competition going. This advice was ignored by the new Minister of Health who repeatedly in public used the argument of bad technical performance of the CyFlow. He says that his statements are based on the unpublished findings of the Muhimbili University, which contradict more than 30 publications and findings of multi-centre studies confirming the accuracy of the CyFlow (e.g. Cassens et al. 2004). Media reports say that some of the civil servants and university employees leading investigations in order to decide about registrations of health products in Tanzania have close ties with businessmen dealing with the import of such products (This Day No. 174).

The practical result of the malady is that a lot of money is spent for overpriced unreliable equipment which is not working very well in the resource limited rural setting and very few CD4 counts are done subsequently keeping people away from life saving treatment.

John Kilaka vividly pictures an ancient game: The "haves" are eating and the "have nots" are dying!

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Traditional Healing Practices Among the Baganda in the Context of Christianity and Western Medicine

Paul Bukuluki

Abstract

This article is based on ethnographic interviews with a traditional healer in Luwero district, Central Uganda. His healing traditions and rituals are based on the Buganda traditional culture and religious practices. This article provides an overview of the Baganda people, their traditional religion, the processes of becoming a healer, culturally bound illness explanatory models, the traditional healing practices/rituals, relationships between healers and Western medical practitioners and relationships between traditional healers and faith healers especially those from Pentecostal churches. It concludes that Christianity and Western medicine exist alongside traditional illness explanations, healing practices and religious beliefs.

Background

Traditional medicine still enjoys an important place in Uganda and other developing countries. A number of authors have stated that 80% of the population in developing countries has its health care needs met through the traditional medicine sector (WHO 1978, 2002; Luoga et al. 2000, Ventevogel 1996). Up to 80% of developing country populations rely on traditional medicines for primary health care due to cultural tradition or lack of alternatives (WHO 2004).

Traditional medicine is acceptable, accessible and affordable by the majority of African people. Even though it was often denigrated as backward practice during the colonial era, it has continued to thrive because of its medicinal and cultural significance among the population. For some communities, it is the only system available because Western medicine is too costly and sometimes unavailable. Traditional medicine has demonstrated its contribution to the reduction of excessive mortality, morbidity and disability due to diseases such as HIV/AIDS, malaria, tuberculosis, sickle-cell anaemia, diabetes and mental disorders. AIDS has added another dimension to the demand for herbal medicines. About 75% of people living with HIV/AIDS patronize complimentary and alternative medicine (Elujoba et al. 2005).

Apart from traditional medicine being perceived as more accessible than Western medicine, studies have shown that it is popular because it blends readily into the people's sociocultural life (Tabuti et al. 2003, Whyte 1997). Traditional medical explanations seem to fit squarely into the people's quest for illness explanations that are culture bound. It provides acceptable answers to people who are attempting to question misfortunes that befell them and their families. When they ask the question "Why me?" the traditional healers provide them with answers that are rooted in their socialisation processes, cultural expectations and relationships with both the living and the "living dead".

Traditional medicine is knowledge, skills and practices based on the theories, beliefs, and indigenous cultural experiences, whether explicable or not, used in the maintenance of health, diagnosing, preventing or eliminating physical, mental or social diseases. Such knowledge may rely exclusively on the past experience and observations handed down from generation to generation, verbally or in writing (Sofowora 1993, WHO 2000, 2002; Diallo and Paulsen 2000, Tabuti et al. 2003).

Some scholars have argued that notwithstanding the strong points of western medicine, the indigenous/traditional medicine is thought to be a strong body of indigenous knowledge with time honoured wisdom (Elujoba et al. 2005, Neumann and Lauro 1982, MacCormack 1981).

Several studies show that traditional medicine concept of diagnosis, treatment, illness explanatory models and therapy tend to take a 'holistic' approach in which psychological, Social, cultural and spiritual aspects of human

existence are taken into consideration (Bichmann 1979, MacCormack 1981, Good 1987, Ventevogel 1996, Tabuti et al. 2003).

In terms of psychological aspects, the therapy of the healer engages the client in conversing at length, understanding their hopes and fears in a given socio-cultural context. "They treat whole people embedded in a society" (MacCormack 1981: 427). The patient-healer interactions and contacts have been reported to be warm, informal and close compared to those that exist between a Western trained health worker and his or her patient (Helman 1985). The traditional medicine practitioners have been documented as experts in counselling and take time to get involved in the patients' illnesses (Tabuti et al. 2003). Notwithstanding criticisms that traditional medicine does not have an adequate scientific foundation, it should be noted that Western medicine practices in developing countries might also suffer from a weak scientific foundation. This may be largely due to lack of equipment and skilled personnel. Biomedicine has been criticised for its technocratic and impersonal character (Neumann and Lauro 1982, Tabuti et al. 2003). Thus medical personnel tend to make far less effort in terms of identifying with their clients' complaints and conceptualise cure in empiricist and technocratic terms, scoring less on the holistic approach.

With respect to socially constructed functions, Bichmann (1979) noted that traditional medicine promotes social cohesion and integration. This is because indigenous therapies are known to focus at healing the disturbed social relations that are purported to have led to the illness. Similarly, Anokbonggo et al. (1990) have argued that traditional medicine aims at curing both the physical/organic causes of a health condition as well as its underlying causes such as aggrieved ancestors or a neighbour's wrath.

In terms of cultural relevance, traditional healers tend to take a cultural approach to diagnosis, illness explanation and therapy options. More often than not, traditional healers share the same worldview as their clients and tend to speak the same language, cultural idioms and illness concepts that make sense to their clientele. According to Bichmann (1979), African medicine is rooted in the indigenous cognitive system and is an inseparable part of African culture. It therefore exploits the cultural resources and makes an attempt to deal with the cultural limitations to health.

The spiritual and moral aspects of healing which characterise the traditional medical discourses make traditional medicine unique and give it an edge over the Western medicine. In many aspects traditional religion and the indigenous healing systems are closely linked. Therefore the quests for health, concepts of illness explanatory models and the therapy rituals have strong spiritual and moral inclinations.

One of the key reasons why traditional medicine is continuing to thrive along side the state facilitated biomedicine is attributed to the reality that Western health care facilities in developing countries are up to now unable to satisfy the medical needs of the population. Uganda is no exception to this. Although there have been efforts to improve access of rural women and children to health care, the health care needs of women and children have not been adequately met by the formal health care system. The Uganda Mid-term Health Sector Review Report (Ministry of Health 2003) identifies a number of gaps relating to access to health care especially in the rural areas: geographical coverage is limited by many of the health facilities not being fully functional; difficulty in physical access to essential obstetric care in cases of emergency; significant institutional deficiencies contributing 40% to 60% of maternal deaths in hospitals surveyed and frequent periods of essential drugs and commodities being out of stock. In addition, the approved posts filled by trained health workers stand at 68% (Ministry of Health 2004). This means that a number of health facilities especially in the rural areas do not have the minimum numbers of health workers needed for the facilities to be fully functional. The doctor patient ratio, for example, is 1: 18000. The official Western health care system in Uganda also has an urban bias. It is estimated that more than half of the scientific medical personnel work in cities and large towns. The country therefore has a heavy burden of disease, inadequate health services infrastructure and insufficient human resources. All these have compromised the effectiveness of the formal Western health care

system and made people more susceptible to resorting to traditional medical practitioners.

Collaboration between Formal Western Medical System and Traditional Medicine

Several scholars have contributed to the debate on the issue of whether the Western health care system should be linked to non-Western types of health care. This debate was boosted by the adoption of the primary health care strategy by the World Health Organisation in the Alma Ata Declaration (WHO 1978). This declaration put greater emphasis on socio-cultural factors in health and health care and the contribution of traditional healers to the solution of prevalent health problems in developing countries was taken into consideration (Bichmann 1986 in Ventevogel 1996; WHO 1987). It recommended that ministries establish and maintain training courses covering the philosophy, principles and essential components of primary health care to all traditional healers (WHO 2002).

It should, however, be noted that over the last decade, the general policy has shifted from the fairly revolutionary concept of viewing traditional healers as allies who can draw upon their valuable system of medicine to perceiving them as providers of potentially effective pharmaceuticals. In the context of these developments, the supports of WHO for traditional medicine has been described as close to merely lip service (Ventevogel 1996: 43). The literature on collaboration between healers and western medicine has been described by Ventevogel as encompassing several perspectives ranging from antagonism: no cooperation with healers based on the assumption that biomedicine is rational and objective and that traditional medicine is an amalgam of superstitious and irrational beliefs, to pragmatism: meaning the tendency to utilise healers as a resource in the expansion of the stagnating Western health care facilities, to idealism: which refers to mutual collaboration with African healers not being interpreted as changing them and co-opting them within a rigid official Western health care system, and scepticism: which raises doubts about the effects of cooperation (see Ventevogel 1996: 49). The latter assume that full integration of the traditional medical system into the formal Western health care system may endanger the unique aspects of healing practices.

It is within this conceptual framework that an ethnographic interview was conducted with one of the popular traditional healers in Luwero district, central Uganda, to assess the extent to which his views about illness explanatory models, healing practices, relationship with other healers, the Western medical health care and the faith healers have value to add to the existing knowledge base.

The Baganda People

It is not possible to fully comprehend the process and responses from the healer that will be presented in the next section without contextualising them to the Baganda history, culture and religion.

The Baganda are the largest ethnic group in Uganda representing 16% of the population. They occupy the central part of Uganda. They are a Bantu speaking people; their language is Luganda. The Baganda are most likely to have come from central Africa where most of the other Bantu tribes are said to have originated (Nzita and Mbaga 1995). The Baganda are socially and politically organised according to clans, which constitute a core cultural feature among the Baganda.

The Baganda are very particular in respect to tracing their ancestry through the clearly demarcated clan structures that largely follow patrilineal lines. Interviews with one of the clan leaders of Buganda illustrates that a clan has a hierarchical structure with the clan leader at the top (Owakasolya) followed by consecutive units called Ssiga, Mutuba, Lunyiriri, Lujja (family linked to one grandfather) and finally the family unit Enju. All these successive units represent families linked to great-grandfathers and ancestors till the top, which represents the greatest ancestral representation of a group of people. A survey carried in 1993 by the Buganda kingdom shows that there are 46 officially recognised clans but popular oral history shows that there are 52 clans in total. Each clan has a main totem (*omuziro*) and secondary totems (*akabiro*), save for the royal clan (Abalangira), which does not have any totem. It has been reported that the success of any member of the clan was considered success of the entire clan (Ssemakula n.d.). In other words, individual clan members were linked to

the fortunes of the whole clan and would claim support from their clan. This notwithstanding, individual clan members had individual property rights and they achieved success as individuals. Clan supremacy up to date is reflected in the traditional naming events where a son is not necessarily given the name of his father but instead given a name from the pool of clan names. The Baganda are clan exogamous. They were (are) essentially agriculturalists growing mainly bananas, sweet potatoes, cassava, yams, beans and a wide assortment of green vegetables (Nzita and Mbaga 1995). Of recent, however, they are increasingly involved in trade activities. Land is an asset of economic importance among the Baganda both for farming and for commercial purposes since most of their land is close to the major cities/towns of Uganda.

Traditional Religion

As aptly stated by Ventevogel (1996:13), "… the practices of traditional healers could not be fully understood without at least some knowledge of the religious premises on which their work is based …" This is because in most cases the illness explanatory models, healing rituals and practices of the healers are rooted within the premises of the traditional religion.

The Baganda have a rich traditional spiritual heritage. They had strong believes in the super human spirits in form of a supreme creator (Katonda), meaning lord of creation and father of all gods. There were three temples for Katonda situated in Kyagwe under the care of the Njovu (elephant) clan. However, little seemed to be known about Katonda and he was thought not to intervene routinely into human affairs.

At the operational core of the Ganda religions were the *balubaale* – humans who were perceived to have shown exceptional powers during their lifetime and were venerated after death. Their spirits were perceived to intercede in favour of the population whenever called upon during significant crises at the kingdom and community level. In some instances, they were referred to as guardians or gods (Ssemakula n.d.).). The *balubaale* were the focus of organised religious activities and rituals and were venerated by all. Before major events like war, installation of clan heads or coronation of rulers, they were consulted as oracles and offerings were made to them at their major shrines. Failure to appease the *balubaale* and their priesthood was associated with invitation of disaster. Each shrine (*ekiggwa*) was headed by a priest or priestess. The priests occupied a place of religious significance in society and they were regularly consulted (Nzita and Mbaga 1995, Obbo 1996).

The most important among the *balubaale* were Ggulu, god of the sky and father of Kiwanuka, god of lightening. There was also Kawumpuli, god of the plague; Ndaula, god of small pox; Musisi, god of earthquake; Wamala, god of Lake Wamala and Mukasa and god of Lake Nalubaale (Lake Victoria). Mukasa was popular to the extent that the king Kabaka would send an annual offering of cows and a request for prosperity and good harvest. Nalwanga, god of fertility, was also popular especially among the women. Other popular *balubaale* documented include Musoke, god of the rainbow, Kitaka, venerated as god of the earth and Kibuuka, the warlord.

According to the Buganda kingdom website and Nzita and Mbaga (1995), the ordinary folk had an innumerable number of lesser spirits (*mizimu*). The *mizimu* were believed to be ghosts of dead people for it was believed that only the body would die and rot but the soul would exist as *omuzimu* (singular of *mizimu*). However, the *mizimu* were not limited to spirits of the departed ancestors alone, they also included spirits believed to occupy mountains, rivers and forests. These spirits are popularly known as *misambwa*. They were believed to be viciously harmful if not kept happy. In other words when *mizimu* enter objects, they are believed to become *misambwa* (Nzita and Mbaga 1995).

The *mizimu* and *misambwa* were believed to operate at family level to haunt whoever the dead person had a grudge with. It was common to find every household having a shrine for veneration of the family's ancestors and a small basket into which offerings of money and coffee beans were made regularly. Other sacrifices like cows, goats and chicken were made while clearing a new piece of land or building a new house. The Baganda did not believe that death was a natural consequence. All death and misfortune

were largely attributed to wizards, sorcerers and supernatural spirits (Nzita and Mbaga 1995, Obbo 1996).

However, interviews with cultural leaders revealed that the people praying for help from gods understood that their personal effort was the key to success in achieving their goals and gods would provide an enabling environment. Thus the popular saying among the Baganda people says, "Pray for deliverance from danger but start running." (Lubaale mbeera nga n'embiro kw'tadde)

Although traditional religion has not remained static due to the influence of Christianity, Islam and formal education, the basic principles and beliefs remain the same and are strongly rooted among the priests who in most cases also double as traditional healers. In the public realm Christianity and Islam tend to be presented as the key faith but in the private realm quite a number of people irrespective of their level of education and socio-economic status engage in different relationships with the *balubaale* priests and traditional healers (also see Tabuti et al. 2003; Anokbonggo et al. 1990). This has symbolism with a philosophical statement made by Senghor (1963) quoted in English and Kalumba (1996: 50): "We could assimilate mathematics or the French language, but we could never strip off our black skins nor root out our black souls."

The Processes of Becoming a Healer

Different types of healers go through different processes before becoming practitioners. The level of traditional medical knowledge and their specialisation tend to determine the processes that people may go through to become healers. For healers who simply have common knowledge of the remedies used by many people and those who have knowledge about family secrets of healing passed on from generation to generation, the training may be less rigorous. However, there is a category of healers who claim to have professional indigenous religious and medical knowledge. The initiation process of such healers is more rigorous.

The type of healer (Mr. Kiiza Gwonyooma) who was interviewed during fieldwork (Fig. 1) bears characteristics that are closely linked to healers

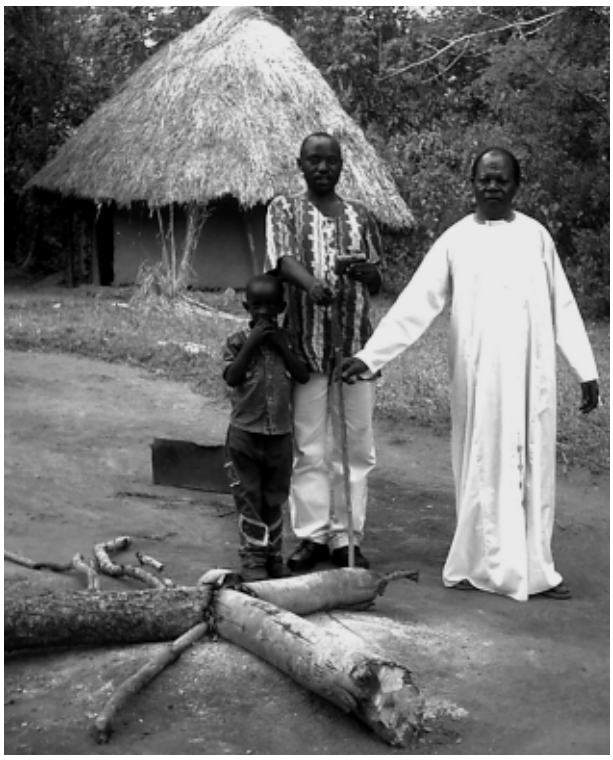

Fig. 1: The traditional healer Kiiza Gwonyooma (right), Denis Bataringaya (research assistant) and his son

perceived to have professional indigenous medical knowledge. This healer doubles as a priest (specialist in traditional religion), as well as a traditional healer. To borrow the term used by Ventevogel (1996), he is a priest-healer. He claimed that he had gone through a long period of training over ten years and his joining of priesthood and traditional healing was involuntary. In his own typical expression, he said:

"On realising that I have some spiritual powers, my father, after consulting with other relatives, started the process of passing me through traditional methods of becoming a 'professional healer and priest'. We went through a period of fasting in the temple of the spirits *mu kisibo kyemisambwa*. Rituals were performed on me. After that, I got the full power and backing of the spirits to serve. I tried to go to school for some time, but this power stopped me. When it brought me back, it used me to do the things it wanted. This power was from my grandfather. I spent a long time serving and praying to the gods (*balubaale*). I got possessed by the spirits which showed me that a patient has certain ailments and it will tell you which herb/medicine to use to cure them. The same spirits guide my priesthood and healing till today. The training process took 6 to 12 years because I continued

going back for further training when I confronted illnesses and spirits that are beyond my ability."

When the healer was asked to describe in detail the training processes he went through to become a healer, he made the following remarks:

"I practiced under close supervision and instruction from a senior traditional healer, my grandfather who had practiced priesthood and traditional medicine for a very long time. He took me through several rituals. During these rituals, I would become possessed by different ancestral and higher *balubaale* (gods) that would tell my grandfather that they want me to become their priest/healer (*mandwa*). The training was through talking to me, taking me to the different shrines, showing me the different items and how to use them in worship, teaching me the different songs that venerate spirits, enabling me to identify one deity from another, how to appease the different gods (*balubaale*), the right way to summon and talk to the gods and ancestral spirits, the dances (*amazina ge misambwa*) for different healing and cleansing rituals, the right way to offer sacrifices and how to prepare and mix the different medicines from plants, birds and animals for healing and protection of the individuals, families or even an entire community."

When I asked the healer) to explain why the gods and spirits would not teach the priest/healer without going through a medium or senior healer, he retorted and said:

"The spiritual power can use a person to do things which everyone will witness and this power would show me the types of herbs which can cure the disease but there are details which you can only learn by practicing under a senior priest/healer by staying with him for longer periods … ah! the spirits or gods in the dream show you the medicine and where to get it but you need to know how to prepare and mix the medicine, how to organise the different rituals and how to deal with sacrifices for different conditions… From your trainer, you also get to know the other healers who are good at treating illnesses which you cannot handle… You cannot treat everything. Even if a child is a genius (*omwana ow'kitone*), he would need someone to help him develop these talents in an acceptable way… He could become dangerous and misuse the spiritual power."

This suggests that most of the priest/healers have to undergo a period of apprenticeship after being identified by their family and senior healers as people selected by the ancestors and deities to become priest/healers. Sometimes it may be that one of the grandsons of the aging healer is selected by the ancestors to become a priest and replace his grandfather like in the case of this healer. In some cases those possessed by spirits are not relatives but when they go to priests/healers to seek for help, spirits retain them at the healer's shrine for training to become healers. Different healers therefore give different versions of how they became healers but most of them acknowledge to have been under apprenticeship of an elderly respected healer for socialisation, confidence building and initiation into priesthood or traditional healing philosophies, rituals and actual processes of preparing and mixing medicines.

A study carried out in Kaliro district, Eastern Uganda, among the Balamoji (Bantu people who speak a slightly different Lusoga dialect) by Tabuti et al. (2003) reveals quite similar processes of becoming a healer. They observed that traditional medicine practitioners learn the craft by practicing under senior traditional healers and the decisions to become a healer were diverse. For some, they state that it was a deliberate choice while for others spirits chose them. These spirits may be ancestral *misambwa gya haaka* or nature spirits (similar to *balubaale* of the Baganda). According to their article, the chosen person is identified in different ways: at home he may experience some difficulties, or a key family figure may die and during the burial and funeral rites, one of the persons may be possessed by ancestral spirits and ask him or her to become a priest/healer *muswezi/mandwa*. Under the guidance of the elders in the family or community, the family organises for the chosen *muswezi/mandwa* to undergo apprenticeship under an experienced and venerated *muswezi/mandwa*.

An interview with one of the cultural leaders (Ow'omutuba) in Buganda indicated that:

"Becoming a priest/healer among the Baganda did not follow a clear way. The spirits may

apply mysterious ways. It may start with a member of the family suffering from an illness, which defies all the different forms of treatment known. The family may first take him/her to the health facilities and then to several traditional healers but with no change in the condition. It is until they find an experienced healer who understands the world of spirits that they wake up and know that this boy or girl has been chosen by the spirits to serve them as *musamize/mandwa* (priest/healer). Rituals are then performed and he becomes a priest/healer".

Tabuti et al. (2003) established similar findings among the Balamoji. They noted that selection of someone to become a healer manifests itself after one suffers from a chronic or difficult to comprehend illness. After the successive failure of attempts to cure the illness through Western medicine, the person seeks services of a traditional priest/healer. While undergoing treatment, it is divined that the person is requested by spirits to become a healer. If the patient agrees, the necessary rituals are performed. When he or she improves, he undergoes a period of apprenticeship of 6-12 months under the healer to learn the art of traditional healing.

Overall, priests/healers tend to report being selected through diverse circumstances ranging from becoming possessed, being selected by their grandparents who happen to be healers themselves, to becoming chronically ill with illnesses beyond the comprehension of biomedicine. It should be noted that even when it is clear that one has been divined by the spirits and given the power to heal and to serve as a priest, he or she has to go through apprenticeship under a senior priest/healer to learn the integrities of the profession. However, as pointed out rightly by Ventevogel (1996) and Tabuti et al. (2003), for a growing number of healers, joining traditional healing is chosen voluntarily and the priest/healers seem to be worried about this category of healers because they do not have a divine calling but are in the profession solely for commercial purposes.

The aspect of apprenticeship with a senior healer is quite an interesting one. It brings together aspects of spiritual endowment as well as those of observation. Apprenticeship is about learning skills and technologies not simply depending on the spirits. It presents an aspect rarely associated with African traditional medicine and culture; that is grappling with the notions of what and how that is closely associated with scientific learning and inquiry. This concurs with Wiredu's (1980: 41) argument that "… despite the lag in the spirit of rational inquiry in Africa when compared with the West, there is within the traditional African thinking some presence of the principle of rational evidence". This implies that although spiritual endowment was important, the practical and technological aspects of traditional medicine through cognitive processes of learning and application had scientific characteristics.

Illness Explanations and Healing Practices

A number of scholars have found that many people do not see disease as a purely physical alteration of bodily functions. It is also perceived as a disturbance of mental, social and spiritual wellbeing of the person. Disease affects both the individual and the social or spiritual order (Ventevogel 1996, Whyte 1997).

Dialogue with the healer revealed that his concept of illness is wide. It touches various aspects of personal, family and community wellbeing. His explanations are closely linked to the personalistic belief system which perceives illness to be as a result of seen but more so unseen forces such as ancestors, spirits and enemies (also see Tabuti et al. 2003). Illness was seen to be associated with one relationship with people (especially relatives and friends) and the ancestral spirits *b´ajjajja abawumula*, the nature spirits *misambwa*, and gods *balubaale*. Although illnesses may have a physical immediate cause, the ultimate cause is in a number of cases linked to relationships with people and the spiritual world. As stipulated in Whyte's (1997) ethnography among the Nyole of Eastern Uganda, people in their quest for therapy also indulge in questioning the circumstances surrounding the misfortune (illness). This is one of the major motivations for going to priests/healers to find not only therapy but also the culturally bound answers to their questions.

The major specialisation of the healer is treatment of madness *edalu*. When he was asked to describe what he meant by *edalu*, he said that this is what is generally referred to as mental

illness. An illness that makes one to behave in ways that deviate from the normal way he or she always does. His explanatory models for *edalu* were that it is caused by bad or evil spirits. He alleged that people come to him after the illness has defied all other treatments, especially Western medicine. He observed that *edalu* in its extreme form can make someone to kill people and drink their blood. This extreme form is linked to what is locally known as *ekitambo,* an obsession to eat human flesh and drink human's blood. He said that this is a compulsive force in one's mind to find human flesh, eat it and drink the blood. This form of *edalu* is caused by an evil spirit, which he (the healer) has power and experience to help a person expel. He also claimed that there are other mild forms of *edalu* that are caused by a strained relationship between the person and his ancestral spirits or through being bewitched by a witch *omulogo* or a sorcerer. In explaining the aetiology and traditional healing processes of *edalu*, the healer said:

"We have evil spirits. For example, Ekitambo, which can get into a person and cause him/her to want to eat dead people. If it was on me, I would have jumped on you and I drink all the blood from your body. You can use all types of drugs but that person will not get all right. When they bring them here, I have the power to fight those spirits and cure these people. I have specialized in treating *edalu*. They even bring people from Butabika Mental Health Hospital and I cure them. There are some mad people who are here."

"Cursing is there and could be a source of many illnesses including madness and bad luck (*ebisirani*). But what removes a curse is cultural *obuwangwa bw'omuntu*. For example, a girl cannot marry her brother. If she does, she will be wrong according to our culture. In such cases a curse is real and can lead to bad luck and even madness. Special rituals involving the entire family have to be performed in order to remove such an abomination (*ekyomuzozo*)."

"Some evil spirits may force a person never to sit in one place but to roam all over the place like a mad person. He/she may not have time to work because nobody can become rich without working … Nakalanga is the spirit which god orders to punish you if you don't do what you are supposed to do. If you don't follow god's ways, you will be punished by going mad, becoming poor and having problems all the time. That means you did not listen to god. He wanted you to do something and you refused. That is a sign that you have to do something."

When the healer was asked to explain how he deals with the condition of *edalu*, he said:

"That person with madness has to bathe with some herbs which the healer gives him/her. The name is my secret. I can't reveal it to you. When you are cleansing such a person, you have to wash him/her with those herbs so that they stop thinking about being cursed, being restless. You also stay with the person for some time, talk with him about his fears at length. You may also encourage the person to confess … he has to know that the misdeed will remain with him if he/she does not confess it."

The healer went further on to explain how the spirits facilitate him in his healing processes.

"I use spiritual power – the spirits are the ones which tell me which medicine to use. There are different types of such powers. There are powers from Lubaale but this one has a limit. *Amayembe* (ghosts) are like soldiers whom you send to catch so and so. That also is a type of power. Then there is power *agali ku_lubere-berye agemisambwa* (stronger and vicious ancestral spirits believed to be harmful if not kept happy) … After I have brought those herbs as directed by the spirits, I boil them. After preparing the medicine, I take it back to the one who told me to get it. After that, he orders me to give it to the patient to use it."

Traditional concepts of illness go beyond the overt physical symptoms to include the social problems that a patient has been experiencing. The causes of these misfortunes may be linked to strained relationships with parents or even members of the extended family, neighbours and workmates. Illnesses like madness can be associated with curses, failure to appease the spirits and witchcraft or sorcery being manipulated against you by those with whom you have strained relationships. The administration of herbs is just a small part of the entire healing process because the physical symptoms are only symbolic of the social and spiritual aspects of

the culturally bound illness explanatory models. As observed by Kutalek (2005: 21), "To treat the patient adequately, it is vital that besides bodily or mental symptoms, the cause of the disease is detected" such that an appropriate ritual is identified and performed to address the socio-spiritual cause of the illness.

Creolization

Culture and the socially constructed healing systems are not static. Once viewed as self-contained worlds of meaning, cultures are now seen as systems of knowledge and practice sustained by cognitive models, interpersonal interactions and social institutions (Kirmayer 2006) that provide individuals with conceptual tools for self-understanding and social positioning. Discussions with the healer indicate that his explanations are influenced both by the traditional religion as well as the dominant Christian faith paradigms. He carefully crafts Christian idioms and relates them to the traditional religion and healing systems in a very creative way. An analysis of his views shows that he uses the systems of meaning of the traditional culture as well as biblical teachings to make his patients who have had an interaction with Christian teachings to understand his spiritual, diagnosis and healing rituals. He displays the mastery of relating the mysteries of the Christian faith with those of the traditional religious and healing systems. Although there is no clear indication that his actual healing methods relate closely to those of the Christian faith, his illness explanations and the examples he uses while describing illnesses and their aetiology bear relationship to those used in Christian faith. The healer makes frequent references of what happens in the churches while trying to explain his belief and healing system. One begins to wonder whether this is some kind of "creolization" where he marries the traditional religious concepts, belief systems, illness aetiologies and therapy with those found in the Christian religious belief system. This is in a way close to the assertion made by Edouard Glissant (1997) in Kirmayer (2006: 163) about creolization: "I call creolization the meeting, interface, shock, harmonies and disharmonies between the cultures of the world … It is not simple cross breeding that would produce easily anticipated results …"

The following excerpts from the healer show how in his explanations he related Christian religious beliefs, interpretations of illness/misfortune and therapy to the traditional religious beliefs, illness explanatory models and healing methods.

Relating Traditional Religion and Healing Practices to Christianity

"When the first Europeans came, they found us already doing our work *tusamila* (traditional worship). We can help women to deliver babies. When a woman dies with a baby inside, we do not operate to remove the baby. We give the dead woman medicine and order her spirit to make her squat and produce the baby. It is like the way Jesus died but believers can call on him and he does things – miracles – for them. But these days they cut the dead women to remove the babies! What brought about this we stopped using our own methods and introduced foreign ones? Then the spirits stopped helping us. If we go back to our proper and old ways, the spirits can come back.
You see those papers! When a person comes with a misfortune he/she kneels down there like they do in church and prays for all his problems. When he/she goes back home, he/she will dream about what she/he is supposed to do. If he/she does it, he or she will be cured. There is no medicine we give him/her. She prays this prayer, 'I have come in this place peacefully. If there is anything I failed to do, I want to go back home and it is revealed to me.'"

"People come with different problems. Like those who are sick come when they have failed everywhere. Doctors can fail to identify the disease and tell you to go for X-ray picture. Then the doctor will know where to start in treating the patient because the X-ray has revealed it. So that is the job of the deity called Muwanga. He takes messages to God and brings answers to us. Like the twelve apostles, there are eleven spirits and Muwanga is the 12th spirit, which came to earth. God created two people Adam and Eve. Muwanga has been there since the beginning of the world. God said they should create man in their form. He was telling the angels. Muwanga, Kizuuzi Kiwanuka, Kitinda … those spirits were there."

"After man had committed a sin, God told the angles that since man had sinned yet he re-

sembled them, they should take him from heaven to earth. Then he called the angels and told Kizuuzi to keep on reporting man's actions to God. Kizuuzi is the one who keeps files of our records. For example, such a person is a thief, a liar, a witch (mulogo) and so on. That is why when you are going to steal. You feel uneasy. Kizuuzi is reporting that you are a thief. He is the one who was leading these spirits. By the time man was brought to earth, he found the misambwa (spirits) on earth."

The last two paragraphs reflect an attempt to interpret traditional religion using Christian concepts and beliefs. It is an attempt to interpret traditional beliefs by explaining them using the Christian faith concepts. It also reveals syncretistic tendencies reflected through marrying together traditional and Christian religious concepts and principles.

The Three Fires and their Role in the Healing Rituals

There were three fires that were burning in the healer's compound (Fig. 2 and Fig. 3). The healer was therefore requested to explain what the fires meant and their role in the diagnosis and illness therapy. Below are excerpts from the dialogue with the healer on the fires/alters *ebyoto*:

Paul: Let's look at your fires (*byoto*). What do they mean?
Healer: These fires mean three make one. Look here where I am seated. Do you see this spear? How many forks does it have?
Paul: Three.

Fig. 2: The three holy fires. At our first visit the healer did not allow us to make photographs, therefore the drawing. Drawing by Armin Prinz

Fig. 3: A patient is kneeling in front of the holy fire

Healer: Where is it located? Is it in the middle of others or on the side?
Paul: It is in the middle.
Healer: You can see the tree under which I am seated. How many stems does it have?
Paul: Three.
Healer: But they are all coming from the same root system.
Paul: Yes, one root system.
Healer: When I came to replace my grandfather in spirit, he had this strength. This tree had been cut down and it dried. Then they burst the stem. But after some time it sprouted. When I came, it brought forth three stems and they are the ones you can see. Three make what?
Paul: You want me to say that they make one.
Healer: Patiri, Mwana, Mwoyo Omutukirivu ('father, the son and the holy spirit').
Paul: I thought that each fire has a meaning?
Healer: Yes. Each has its meaning and each has an owner. When we come to these fires, we now go to the power of the *misambwa* (deities or spirits). They are the owners of these fires. The first alter/fire is for Nakalanga spirit. The one in the middle is for Muwanga. Malaika (Angel) Muwanga whom you may equate to Angel Gabriel if you are a Catholic. He is the one who brings messages. The third one is for Ddungu. That one is the one who searches for the herbs. He is the one who informs us about all types of herbs we should use – Musambwa. So whenever I want any herbs, I go there and rekindle the

fire and do whatever is required of me. Then after that, I go in the shrine and start praying. Then after that I go for the herbs. If I am to go the following day, I have to pray for three days and then things are revealed to me. Whenever I prepare these herbs I have to take them back to Ddungu to ask if it is all right to give it to the patients. Then I can distribute the medicine to all herbalists who need it.
Paul: How did you know that you have to make 3 fireplaces? How did you come to know about it?
Healer: Like I explained to you, those *misambwa* appeared to me long ago when I was still at home. This spiritual power brought me to this place, which has that power. They told me to come to this place to replace my grandfather. They told me I would find a dead stamp of a tree, which I have shown you, and the tree would sprout which it did. I was just fulfilling what the spirits had told me. They are the ones who told me to make the fires. It is like when a reverend goes to a theological college and the bishops perform some ceremonies on those reverends. These ceremonies enable them to go and start preaching.

His explanations also show clear tendencies to borrow concepts from the Christian religious faith and use them to interpret those of traditional Baganda religion. Although the major motivation for doing so is not clear, it could be that because the healer knows that most of his clients are Christians, linking his illness explanations and healing methods to Christian principles and beliefs may win him credibility and a larger clientele. This is because his clientele may easily understand him and identify with the illness aetiologies that he presents to them during the diagnostic and healing rituals. It could also be that his interpretations are a result of his interaction with the Catholic Church doctrines because Luwero district has many Catholic churches.

Relationship with Biomedical Practitioners

During the period when Uganda was a British colony, traditional medicine was frequently outlawed (Obbo 1996; Dialo and Paulsen 2000) and until recently, traditional medicine was only being tolerated but not recognised. Although there are some interactions between the Ministry of Health (MoH), Uganda, and the traditional healers especially in regard to the herbal medicinal aspects, it is still elusive. Of recent, however, a draft policy aimed at recognition, coordination and regulation of traditional medicine has been developed. Collaborations between modern medicine and healers are more visible among some non-government organisations. Notable among these is "Traditional and Modern Health Practitioners Together Against AIDS" (THETA). THETA mobilises traditional healers for training in HIV/AIDS related issues, facilitates testing of herbs that healers claim cure AIDS and serves as an information sharing between healers and the willing health workers. However, there is still limited partnership between the two medical systems. Some of these interactions are simply at a level of sensitising healers and researching on herbs but not mutual and equal partnerships. The current events towards collaboration are more at the political/policy level in response to pressure from the demands by associations of traditional healers to be recognised by the government and are yet to formally trickle down to the health facility level.

Although this is the analysis from the literature and ministry bureaucrats, my interactions with the healer indicate that at an informal level some health workers refer patients to him when they fail to respond to Western biomedicine treatment. In respect to collaboration with health workers, the healer made the following remarks:

"Fellow traditional healers refer some patients and also some health workers know me and they refer some patients to me. Even those from Mulago and Butabika know me.
For example in case of AIDS, ignorance about its cause was the reason why we thought it came through charms *juju*. Most traditional healers have learned a lot about AIDS through The AIDS Support Organization (TASO) and THETA. We did research together with modern medical doctors for 3 years. Yet some of them despise us and yet for us we don't despise them."

This is similar to the categorisation made by Ventevogel (1996) that the interactions between Western medicine and traditional medicine is characterised by antagonism, no cooperation and pragmatism. In Uganda, aspects of pragma-

tism and cooperation between healers and Western medical practitioners are largely in respect to research on the medical properties of herbal medicine and training of traditional birth attendants. There is very little or no tolerance for aspects of spiritual healing involving traditional healing rituals and divination. These practices are viewed as inhibitive to and incompatible with scientific, technological, economic and philosophical development which biomedicine espouses (see Gyeke 1997, Horton 1997). The one sided interest of many scientists attracted criticism from various scholars (Last and Chivunduka 1986). These scholars see the tendency by scientists to ignore the social and spiritual aspects of the healers' work in preference for herbal aspects as a form of exploitation through robbing of the healer's indigenous knowledge.

Competition and Antagonism between Traditional Healers and Faith Healers

Over the last two decades, there has been a proliferation of many Christian based charismatic churches in Uganda. There are over 100 registered churches of this kind in Uganda and there is a lot of competition among them for getting new converts and retaining them. One of the major characteristics of these churches or Pentecostal denominations is the faith healing. For most of these churches, their major message and very foundation is faith healing and miracles. This is depicted from their names; Miracle Centre, Liberty church, Deliverance church etc.

According to the Apologetics index, one of the Christian websites, faith healing refers to healing that occurs supernaturally, as the result of prayer rather than the use of medicines or the involvement of physicians or other medical care. This website hastens to add that while faith healings do take place today just as they did in the early Christian church, the teachings of some churches, movements and individuals on this subject amount to spiritual abuse.

While performing the faith healing rituals and prayers, the most frequently quoted scriptures from the bible are Luke 17: 11-19 which states that:

"Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord … And the prayer offered in faith will make the sick person well; the Lord will raise him up … If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective."

Teachings on faith healing vary from one denomination to another. Many attribute all sickness to demonic activity and include exorcism of evil spirits and substances as a tool of faith healing. Others, especially certain pastors associated with the Pentecostal church, blame sickness on anything from unbelief to sin, and often tie promises of healing to slick pitches for financial contributions. An article that appeared in one Kenya Newspapers, The Nation (Sep. 29, 2001) about miracle healers brings this discussion into perspective:

"The question, however, is: Who are these people who claim to have been cured? Where do they come from? Why is it that they are always strangers whom nobody has seen before? And why are they never seen again thereafter? Each Kenyan town has its easily recognised blind beggars or cripples. If any of these were healed, the whole town would acknowledge that a miracle had been performed. But the great evangelists come and go, and these blind beggars and cripples remain exactly where they were before. This is not in the biblical tradition of miracle healing. Jesus Christ, in whose name the evangelists claim their healing powers, performed his miracles in the open and invited verification. In Luke 5: 12, after Jesus had healed a man of leprosy, he told the leper to go at once and show himself to the priests for it to be confirmed that his leprosy had, indeed, been healed."

Thus although these faith healing churches have attracted many believers, many, too, question the authenticity of the miracles these churches claim to facilitate. The general belief in the population does not necessary say that miracles cannot happen in the Christian faith since they are written all over in the bible, the point of contention has been the extremism, false claims and commercialisation of miracles.

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Contributions to Visual Anthropology

Madzyoka – Psychotherapy at Chief Ndamera's Village, Malawi/Mozambique Border

Moya A. Malamusi, Gerhard Kubik and Yohana Malamusi

In the context of our current, three-year research project[1] the authors of this article had an opportunity in July 2005 to visit a little known place in the Lower Shire valley on the Malawi/ Mozambique border: a cluster of villages under Sena Chief Ndamera. Ndamera is a place in Nsanje District close to the Malawi/ Mozambique border. Culturally, the Chisena-speaking people have been documented by travellers and historians since the 16th century. The name Sena derives from a town of the same name on the Zambezi, founded as a Portuguese trading post in 1531. Little known written sources about Portuguese rule in the Zambezi valley and on the Mozambique Island continue to be discovered in European and other libraries, such as, for example, a most informative text in Latin written in 1644 by a Polish missionary and traveller, Michael Boyms (Wallisch 2005). On the general history of the region under Portuguese control from 1500 to the 1800s there is also Kings M. Phiri's comprehensive article (Phiri 1979) besides many other writings.

The reason why Ndamera was our first choice in the current project, was a specific one. In 1967, one of us, G. Kubik (in the company of Maurice Djenda, ethnologist from the Central African Republic) had visited this place under the current chief's father. Among the many recordings made there was one of a young woman near the chief's residence by the name of Fainesi, who had turned out to be an expert in yodel (*chingolingo*) as used by women when pounding maize in the mortar. These fascinating recordings have been published (Kubik and Malamusi 1989) and republished. 38 years later, in the context of the present historically oriented project, we wanted to check whether Fainesi was still alive and could perhaps be recorded again, thereby assessing stability and possible changes in her style and repertoire. That prospect induced us to revisit Ndamera.

Our logo for this series: Azande children inspecting the camera of a visual anthropologist.
Photograph: Manfred Kremser

We were very well received by the present chief, son of the late Ndamera, who was in power in 1967. (The Asena, are patrilineal.) He is a person highly educated in local historical knowledge, and he was very willing to record oral history for us, explaining how his ancestors had come here from Mozambique, planting the foundation tree of this village. This is customary in many rural societies of south-central Africa. Symbolizing the fact that those immigrants were taking roots in this place, a hereditary name for the chieftainship was coined: *Ndamera*, meaning: "Here I have grown (*ndamera pano*), not anywhere else. And I will never leave this place again." (Recording tape no. 2005/2, 1/1).

Unfortunately, as far as Fainesi is concerned, we were not successful. Nobody even remembered her, which demonstrates that just 38 years is a long time in the "public" memory, outside the chief's tradition. Apparently, Fainesi was an employee of the late Chief Ndamera whose house still existed when we were visiting the area. There were other people living inside possibly not related to the chief. At the present chief's compound it was believed that Fainesi could have been a household employee of the former chief and that she might have gone back to her home area after his death, possibly to Mozambique. However, as it often happens in fieldwork with its uncertainties, if one fails to find one thing, one may succeed in finding something else. While staying at the chief's compound we heard about a very active female *sing'anga* by the name Esther, a common bibli-

cal name in the area. We had already recorded several "Esthers" at Chief Ndamera's place. But this one was Mai Stamidya Stafford. *Mai* means "mother", Stamidya is the local pronunciation of Esther, and "Stafford" derives from an English-language surname. After all, Malawi had been a British protectorate in the first half of the 20th century.

Sing'anga is the term in the Chichewa language of Malawi by which people identify a local healer or medical practitioner. There are several specializations among the *asing'anga* (plural term) in the country (Malamusi 1999). Some are herbalists, others are specialists in the detection of witchcraft, others have a reputation of being able to communicate with the world of the spirits (*azimu*). Yet others combine several of these abilities and may also act as "prophets", as was the case of the late Nchimi (Prophet) Chikanga Chunda in northern Malawi (Kubik 2003b).

Mai Stamidya Stafford was of the *azimu* type of specialists. In her therapy sessions, she would act in a trance-like state, first identifying a patient's problems in personal contact with her in her consulting room, then acting out symbolic solutions in spectacular dramatic performances in front of onlookers outside her house, with the patient quietly watching. On Tuesday, July 12, 2005 we were able to attend one of her sessions for a sick woman, approximately 30-35 years old, complaining about what appeared to be clinical depression and general weakness. The event took place not far from the present Chief Ndamera's residence. The chief did not take part in it. We were walking to the place with an assistant from the chief's compound, and found many people assembled outside the house of Mai Stamidya. They were a large crowd, some hundred people of all ages, including many children. Some of her assistants, all elderly men, had brought the drums to be played during her show. Meanwhile she had retreated with the patient to her consulting room. We were not allowed to enter the house, but were able to listen to and record the conversation on tape from outside, thereby getting a glimpse of the kind of therapy she was giving a woman whose problems she had diagnosed as caused by witchcraft.

Mai Stamidya spoke with the voice of the spirit whom she had invoked (on tape 2005/2/I 2). These sections are almost incomprehensible, since her voice is somewhat disguised. In addition, the language is Chisena, with occasional borrowings from some other languages. Inside the consulting room there were three people: the *sing'anga*, the (female) patient who had pronounced her complaints and another woman accompanying the latter. This is in conformity with local custom. A sick person is always accompanied by someone from the family to the hospital, never left on her own. This also applies if treatment is sought in a Western-style clinic. Someone from the family usually sleeps there in the same ward as the patient.

One of us, Moya A. Malamusi, took field notes about the event in the Chichewa language, from which we now translate the following paragraphs into English:

"Mai Stamidya Stafford is one of those medical practitioners we call *asing'anga amadzyoka*. We found her by chance in the village of Ndamera at the time of our research. In the morning of July 12, 2005 at about 9 o'clock we noticed sounds of drums (*ng'oma*) coming from a certain direction. At first we did not understand what was going on, but Chief Ndamera explained that a *madzyoka* ceremony was taking place conducted by a female *sing'anga*. We then took the opportunity to go there and see for ourselves what was happening.

As soon as we arrived on the spot, we noticed that the *sing'anga* was already inside the house attending to a client. She was singing, and by clairvoyance she identified the trouble her client had come with (*anali kuunika kuti adziwe bvuto lomwe wabwelela*). This is like divination (*maula*); the *sing'anga* sees the client's problem. In Chichewa the verb *kuunika* expresses the idea of clairvoyance. Literally it means "to hold up a lamp", in order to see someone's face, for example. By analogy, the *sing'anga*, through her spiritual power, acts as if she were "holding up a lamp" to understand the psychological trouble of her patient.

We were not allowed to enter the house. Her assistant guardian was blocking the entrance to the corridor. Inside it was very dark, though outside there was full daylight. However, we were able to hear the talk going on inside in the dim light of the consulting room. I had to make

a quick decision. I simply decided to stand near the window, and, covered with a sack-cloth, recorded the therapeutical conversation from outside. We had arrived a little late, finding that the treatment had already started. And yet I was able to record a great deal of what she was singing or talking by holding my microphone close to the window. Only the beginning of the session is missing on the tape, while essential parts have been recorded.

As soon as the *sing'anga* became aware of our presence, realizing that we were standing outside and waiting to see what she would do next, she began to hurry up her procedure with the treatment of her client. Eventually, she was telling the sick woman that her problem was caused by a man who wanted to spoil her life (*amuononge moyo wake*). The background story was this: The woman whom the *sing'anga* had subjected to divination (*akumuombezayo*) had refused that man. For this reason he applied medicines (*anachita mankhwala*) so that this woman should become sick (*abvutike ndi matenda*). This is what the *sing'anga* Stamidya was saying at the time she was "shining a light" (*akumuunika*) on that woman, by inspiration of her spirits (*madzyoka)*.

Thereafter she came out of the house to the open space in front, where the drums would be hit with sticks (*ng'oma zimatinthimuka*). We noticed that she had a strange appearance. This was to let everyone know that she was now "following her spirits" (*anali pambuyo pamizimu yakeyo*). The way she was dressed up was according to the conventions of her profession (*anabvala mwa luso lake pa ntchito yake*). She was wearing a brown hat like a male person. Later she exchanged it for a red, "revolutionary" cap. Everywhere on her forehead and around her neck there were appendages, such as beads (*mikanda*), cowrie shells, and also small sewn medicine bags (*zinthumwa*) to help her in her work. Around her waist she was wearing a broad belt from the skin of a python (*chikopa cha nsato*). In her right hand she held a dummy (*chifano*) of an automatic rifle such as had been used in the Mozambiquan liberation and civil wars (Fig. 1). The purpose of this symbol was to express the battle with the man who had bewitched her patient (*yemwe analodya nkazi yemwe akudwalayo*).

In all, her appearance was designed to give onlookers a frightening impression (Fig. 2). During the public part of her session, she was acting most dramatically, dancing to the sound of the drums in front of the people who had gathered to watch her. In addition to the gun in her right hand she was also carrying a small axe (*kankhwangwa kake*) in her left (Fig. 3, Fig. 5). All these objects were meant to be weapons of retribution for the evil acts committed by the wizard, liberating the client who had become a victim of witchcraft medicines. In her dramatic presentation, the *sing'anga* included episodes inspired by the Mozambique war; she would act as if performing a military exercise, aiming her weapon at a target, to express that she would shoot down the culprit (*munthu wachipongweyo*). He would die, or at least get sick in the same way he had inflicted disease upon his victim. Thus, the disease would change direction and return from her patient to the "owner" who had sent it.

At that point (audible on the tape, and seen on our video, No. 92 S-VHS PAL) she was singing a song instead of allowing her patient to do so (Fig. 6), but with words meant to express thoughts she considered to be appropriate for her patient to articulate. "This year I will die with my things, because I refuse those things." "Those things" (*zinthu*) refers quite obviously to her relationship with the man who bewitched her, reconfirming the need for complete detachment.

At *madzyoka* ceremonies there is often much dancing (Fig. 4), especially by an assistant person who dances together with the healer (*ng'angayo*). That person can also be the lead singer of many different songs. When the healer dances herself, she may also sing, or otherwise explain to the audience what she has discovered about the disease of her patient. Occasionally, she stares into space to communicate with her spirits. Sometimes it takes long until her spirits come to the end of their searching (*kufufuza*). Several drums played with sticks by elderly men take part in the *madzyoka* ceremony. There is the big drum called *magamba*. The other drums are *sonjo* and *gaka* (the smallest). Then there is *muleji*, a type of seedshell rattle made of five shells of the *Oncoba spinosa* fruit, threaded on a stick. The *madzyoka* ceremony serves as a therapy for the afflictions of various patients seeking help."

Fig. 1: During her performance Mai Stamidya Stafford holds a dummy rifle in her hands.

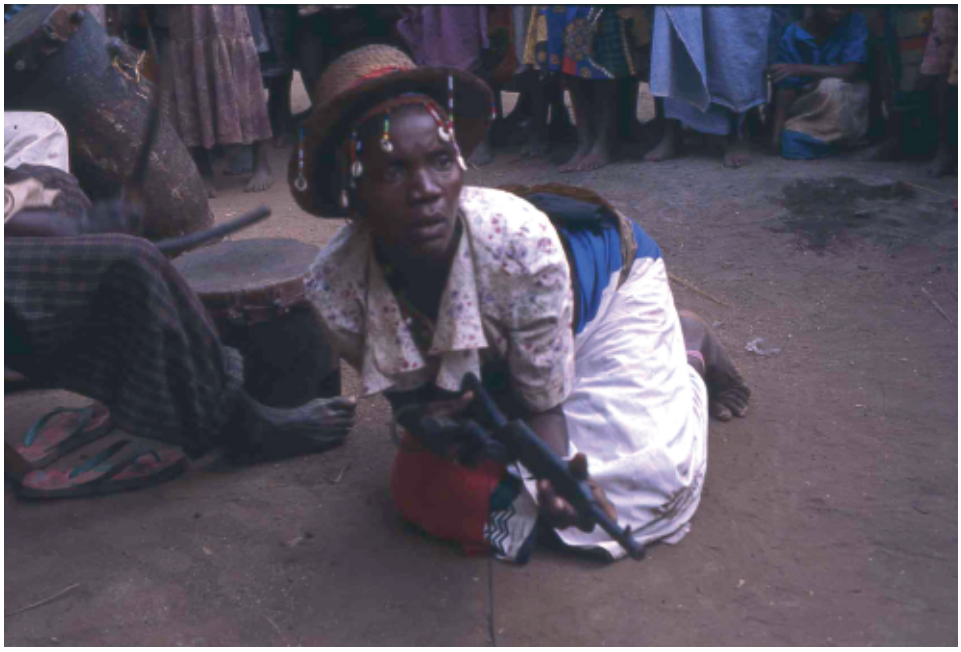

Fig. 2: She kneels down. Her appearance is designed to give onlookers a frightening impression.

Fig. 3: In her left hand she is also carrying a small axe (*kankhwangwa kake*).

Fig. 4: At *madzyoka* ceremonies there is often much dancing.

Fig. 5: The objects she is holding are meant to be weapons of retribution for the evil acts committed by the wizard.

Fig. 6: Singing a song to express thoughts she considers appropriate for her patient to articulate.

This is not the only occasion on which we have ever documented *madzyoka*. In 1987, one of us, Gerhard Kubik (accompanied by Donald J. Kachamba and Lidiya Malamusi) was able to make a cinematographic documentation of *mazooka* of Mozambiquan refugees of the Amarenje ethnic group at Muloza, Mulanje District, Malawi, close to the border. There is a BETACAM-SP archival copy of this film (no. 69, July 3, 1987) in the Ethnological Museum, Berlin (Department of Ethnomusicology). Some analytic information can also be found in Kubik (2003a: 108-110), plus comparative materials from Zambia and Angola (pp. 124-131, 138-152).

Summarizing, we can say that Mai Stamidya Stafford is quite a celebrity in the area of Chief Ndamera. With her frightening appearance, her "drugged" look, staring up into the sky, and the dummy machine-gun in her hand, she displays a style of dramatic action that is comprehensible and acceptable to the present generation[2]. Obviously, she appeals to a generation that has had some experience of the dreadful war between the FRELIMO and RENAMO liberation movements in Mozambique, a war that ended only a few years ago. At times there were over a million refugees in Malawi, many in refugee camps across the country, but many also working as household aides.

Mai Stamidya is a *sing'anga* who seems to have great experience in treating psychological problems, as in the case we have witnessed: that of a woman who had rejected the sexual advances of a man, but then found herself still being haunted by strange feelings. The *sing'anga* identifies the problem and prescribes a cure, in this case complete withdrawal of libidinal investment from that man. To achieve that, she activates the forces of projection in her patient, using the model of witchcraft accusation, generally accepted in this society. And she suggests that the man was exerting witchcraft "to spoil her life" (*amuononge moyo wake*), thereby explaining her uneasiness. The aggressive drama she acted out in public with her gun served to help her client to identify with the idea and detach herself from the object (decathexis).

Psychotherapy of this kind involves three parties, the psychotherapist (*sing'anga*) demonstrating her superior abilities and power of suggestion, the audience accepting her authority (which introduces an aspect of mass psychology into the event) and the patient finding relief through the solutions offered and acted out symbolically by the therapist. It is relatively easy to translate the psychodynamics of the intervention from its local symbolism into the language of psychoanalytic theory. The method used in the present case by Mai Stamidya as a therapist is most interesting in its theoretical implications: she was helping the patient to reinforce her defense mechanisms (by stimulating projection), thereby strengthening her super-ego.

Notes

[1] „Musical Cultures of East and South-East Africa: Historical Perspectives", Project no. P 17751 G06, financed by the Fonds zur Förderung der Wissenschaftlichen Forschung, Vienna. We gratefully acknowledge the invaluable help given to our research endeavor.

[2] It is not surprising that she cultivates a certain consciousness of her status. After we had recorded and video-taped the session, we wanted to talk to her and ask a few questions. Unfortunately, she demanded a sum of MK 10.000 (about Euro 80) for talking to us.

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Traditional Healing Practices Among the Baganda in the Context of Christianity and Western Medicine
continued from page 18

It is within this context that the traditional healer was asked to give his account of the relationship between traditional healers and faith healers. Below are the excerpts from the dialogue with the healer on the relationship between traditional healers and faith healers.

"I believe I am the original and these religions found us already in existence. What I know is that faith healers are also involved in chasing away demons. We like it very much but they keep on blaming us. Yet they come to us and we give them encouragement. I have no problem with religions. These religions are the ones who have a problem with us … When I was young I used to attend their services but after some time, I decided to leave them alone. When you take money to them, like a church offering, they accept it. But when you (healer) lose a person, they tell you they can't come to your place because you have shrines. The missionaries wanted to pray for us but before they came we could pray for ourselves. The missionaries were forced to call us wizards, *balogo*, and sorcerers. In 1957, they put a law blaming traditional healers. We are fighting to remove that law."

Up to this level, the healer was more generic focussing on the entire Christian domain and showing how through legal action, the missionaries had succeeded in branding the activities of the traditional healers illegal. This shows that there was antagonism, which climaxed into declaring the traditional healing practices as illegal and labelling their practices as witchcraft.

When the healer was asked to describe their relationship with the faith healers and or Pentecostal churches, he made the following remarks:

"Those people claiming to be *balokole* (saved) from the Pentecostal churches despise us and talk bad things about us. Yet they come to us and get our spiritual power and use it to heal people they pray for. It is our spiritual power, which enables them to heal people … They come and tell you that they are pastors. They want supernatural strength to do their work. You give it to them to go and heal people. Just as you can come here and you ask for a prayer book and I give it to you. Then you go and use it to pray … If you go there to that pastor, taking all the fetishes (*bibo bya bajaja*) and request him to burn them, when he is going to burn them he says, "My lords spirits I cherish you. Please come out of the fetishes quickly. I am the one who needs you. I want you in my life. If this one does not want you, I am going to burn the fetishes but you come out." Then he takes that strength himself. Then you may think that such a pastor has power and can perform miracles. Yet they are using our power. They even lie that they can cure AIDS. We don't tell lies. We have all types of powers which can do many things but lying of the highest degree is among the faith healers *balokole* by saying that they can heal HIV/AIDS!"

The healer's remarks show that in the private realm, some of pastors (faith healers) consult the healers to get more powers for healing. This is a contradiction with the public image given by the faith healers. They claim to be totally opposed to the healing methods and ideologies of traditional healers. The pastors claim that the healers have evil spirits, which are manipulated to cause suffering to the believers. The healers are associated with demonic power and the pastors tend to be associated with the Holy Ghost power. Of recent in the Ugandan media, however, there have been several reports that some pastors have started using powers from the spirits and *balubaale* in their healing practices and rituals. It is claimed that some go under water in the lakes and rivers to get power from *balubaale* and *misambwa* in order for them to heal. This is controversial because the faith healers claim to do their miracles in the name of Jesus whose healing principles are in antagonism with the spirits and *balubaale*. There have also been clashes among pastors of faith healing churches accusing each other of using powers from the deities/demons *balubaale* to perform miracles. In this context, the remarks from the healer may carry some level of substance but there is still limited evidence to substantiate his arguments.

Conclusion

Traditional religion among the Baganda and traditional medicine practice are intertwined and self-reinforcing. Traditional religion and health beliefs are not static, they have been changing but their basic premises still remain at large. There has been reconstruction of traditional religion and illness explanatory models by relating them to the dominant Christian teachings that to some extent shows some elements of creolization and syncretisticism but a more robust conclusion about this phenomenon requires further research. Although at the political level there are tendencies to recognise the contribution of traditional medicine, this is yet to trickle down and filter through the Western medicine institutions in Uganda and Buganda in particular. The kind of collaboration that currently exists is at superficial level but it reflects some aspects of pragmatism. It focuses on validating the medical properties of some plant resources used by herbalists and training traditional birth attendants but almost totally abhors the spiritual and psychotherapeutic aspects of traditional medicine. The relationship between faith healers and traditional healers bears elements of cooperation at the personal level in the private realm but exhibits antagonism in the private realm. What seems to come out clearly is that traditional illness explanatory models, traditional religious beliefs and quest for therapy based on traditional religion and healing worldviews continue to exist along side the Christian faith and the formal Western medical health care system.

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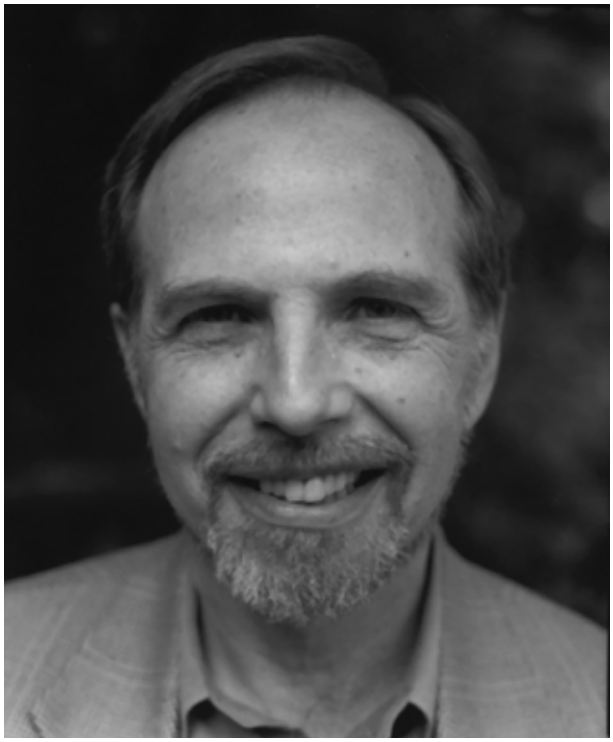
An Interview with Arthur Kleinman

Ruth Kutalek

March 16th and April 13th 2006, Department of Anthropology, Harvard Medical School. This interview took place while doing a project on the didactics and theory of medical anthropology at Harvard Medical School, financed by the Fulbright Commission.

What brought you to medical anthropology?

I became interested in the intersection of culture and medicine before going to medical school. That interest did not come out of a professional background so much as it came out of just an interest that I had in history, the humanities, anthropology and how they relate to medicine. It was clear that one of the powerful ways that the social sciences and the humanities relate to medicine is through culture so I brought that interest into medical school and while I was in medical school I began to read widely in that area. When I left medical school I did my internship at the internal medicine department at Yale-New Haven Hospital in New Haven, Connecticut and went from there to the NIH (National Institutes of Health) and the NIH – this was the Vietnam war – sent me to Taiwan. In Taiwan I was there for two years initially and for my wife, who is a China scholar, and I it was like being in a kind of candy shop because all things that I was interested in were there. So I was studying initially leprosy and tuberculosis and all the issues around them were either related to cultural aspects of stigma or to the social course of the disease or to some of the social and cultural aspects of the health system. I also became very interested in the various kinds of practitioners and practices. Then my career just took off from there so I went back to Taiwan after my residency in psychiatry to do field research in 1975-76, which led to my book "Patients and healers in the context of culture" (for all publications mentioned in this interview, see references below) which uses Taiwan's medical system to try to understand how culture and medicine come together across the sectors of the professional system, the folk system and the popular system of patients and healers, patients and popular care, selfcare etc. From there, out



Professor Arthur Kleinman

of the initial book came a set of interests that related to what clinically I found most compelling: e.g. the distinction between illness and disease. Then I developed a method for clinicians to understand how social factors are important in people's lives and disorders, which is called the explanatory model's method. With that I also developed a method for comparing medical systems across cultures. In 1973, during the time when I was a resident – actually because I had a number of years of post-doctoral fellowship beforehand and afterward – I wrote four articles that more or less defined my whole career. One was called "Medicine's symbolic reality" which is really a theory about the intersection of the social construction of disease categories, the politics of health care and the culture of science. I wrote another journal article that year, "Toward a comparative study of medical systems", and another on public health in China, "The background and development of public health in China" and a fourth article "Some issues for a comparative study of medical healing".
That was the time in which a lot of people were writing about cultural aspects of care but few of

them had a really deep anthropological background and very few, I thought, really could bring theory to bear on circumstances. I had, by that stage, studied anthropology and got my master's in anthropology, which is all I needed at that stage, and had read widely and I felt quite prepared to build my career around medicine and culture as they related to various aspects of clinical practice, that excited me. One interest was problems like depression, pain and the variety of somatoform conditions, another interest was in communication and the doctor-patient relationship, and a third set of interests that I had at that point were how meaning gets embodied in either physiology or pathology. That's how my career went: my career basically followed these different tracks in terms of research and teaching. I built major research programs, first at the University of Washington, then here at Harvard. I have also built major teaching programs. It's so much that I can't really summarize it. I effectively had more than 50 research grants, I have had more than 50 Ph.D students, more than 200 post-doctoral fellows have worked with me. I would say that all those things came together. By the time of the 1980s, when I wrote "Patients and healers" everything was set in train, it was going to happen. The "Illness narratives" came out of my clinical work. "Rethinking psychiatry" came out of my clinical teaching and clinical research. My book "Social origins of distress and disease", which was the first study of survivors of the Cultural Revolution, came out of my fieldwork in China. So I had a huge amount of research and teaching – a large amount of it – that reflected the fact that I had been protected in the early part of my career by a group of mentors so I didn't have to do anything that was not research and teaching or my own clinical work. So I did not have to do administration, especially. I did no administration until 1990. In 1990 I had to take over, I had been delaying it for a few years, but I finally had to take over the Department of Social Medicine. I chaired that for a decade. And then, what I produced in the 90s … I had a lot of journal articles and the like and a number of research trajectories, edited books. I did the Social Suffering Series, I became very interested in that. I brought out my own book "Writing at the margin", a book of essays, and then I built up so much steam, in the 90s, slowly, that right now I am in a period of high productivity. So I just had my own book came out ("What really matters"), I have had one edited volume appear ("Global pharmaceuticals"), I have another one on SARS in China, and I have another one on AIDS in China coming up. I have a lot of things that are occurring. You know, in my career I have been able to be highly focused in medical anthropology, in cultural psychiatry and periodically, like in the "Illness narratives" or in this new book "What really matters", I have tried to write for a more popular audience. So I think my career has been advanced by three things: One, the fact that I took on the subject at a critical moment when medical anthropology was in need of theoretical elaboration. I had a big effect on medical anthropology in part because of the needs of medical anthropology. Secondly, when I was doing all this there was a new wave developing, a wave in medicine of attention to culture and that in anthropology of attention to medicine, and that carried my work and me like a surfer forward. So that was the second thing. And then the third thing was that I had a tremendous amount of protective time both in post-doctoral fellowships and when I was a young academic. So I did a tremendous amount of fieldwork and was able to concentrate on research and teaching for about 20 years. That was due to the wonderful mentors who picked up the ball for me so that I did not have to do things like chair departments and go to committee meetings and things like that. And I didn't until 1990, which meant that for 20 years I could read, do research and write.

Can you tell us something about the recent book you wrote?

My most recent book is "What really matters. Living a moral life amidst uncertainty and danger". This book is the culmination of my career as a medical anthropologist, a psychiatrist and a China scholar. And what it tries to do is to reach into research data, into clinical work, into personal connections in order to provide some wisdom about lived experience, about life. So what do we learn from all these kinds of studies I have done that tells us anything important about living? And this is written for a broad audience to start a conversation. In a sense the argument is modeled on Michel de Montaigne's "Essays", which are great essays written in the 16th century in

France about various aspects of life. So this book looks at things like living with a serious disease; how do you deal with long term atrocities associated with violence that people commit on behalf of the state and then the rest of their life try to work out in the course of their lives. It is also about making a commitment to things like humanitarian assistance programs and being able to sustain it in the midst of the most difficult and bleak prospects in places like war zones in Africa or in central Asia. It's about pointing out again, what I think medical anthropologists have often done what very few people have paid attention to, that life is extremely dangerous, that the risk model that is not only the basic model in epidemiology but has become the basic model in so much of social life, from social policy to security affairs, just doesn't work because it suggests that you can break down what we face into little bits and pieces and for each bit and piece you can predict likelihood of occurrence, future outcomes and the like, but that's not how we live our lives. We don't live our lives dealing with only one issue, we live our lives in a setting of lots of dangers, from health problems to financial problems to problems in the moral sphere, and way beyond us, for our societies and globally, political problems like political oppression etc. to gender related problems. All of these, you can't just deal with them in an isolated fashion. They come together and they constitute the great set of dangers that we face. And my argument is that from an existential position, which is what I try to advance, every society, yours and mine, and global culture generally, carries a big lie and the big lie is meant to deny the seriousness of these problems and to get us on our way of buying things, because basically global culture is about supporting the global political economy of consumerism. I am not against some degree of consumerism. I do think we live in a world of excessive consumerism, but I do think that there is something fundamentally wrong when you fail to understand what life is about. Not just in a poor central African country but in a rich Austria or United States. O.k? Obviously there are plenty of people in the world who have all kinds of resources, financial, social, health resources that somewhat protect them from the dangers I am talking about. But only to a limited degree. And every one of us in the course of our lives before we die, for example, is going to experience catastrophy in the health sphere. If not in ourselves than in a loved one around us, within our family, our friendship circle. And the other set of problems that we face in the world today are very … you can't miss them. If you happen to be able to do well in society, there is no question that if you interviewed carefully and people ask you what your project was, what your program was, somewhere along the line you were checked and maybe ultimately you are checked as well. Most of us feel that in our intellectual programs or artistic programs or ethical programs, that there is a limit to what we can accomplish, that we have had defeat, various kinds of failures and I think that's what I am writing about, I am trying to write about and take it seriously. And then also about the uncertainty of this life, which means that although the certainty is there that we are going to die, everything else is uncertain. This great uncertainty is extremely difficult for people as well because how do you manage that, how do you deal with uncertainty in the course of your life?

What I am suggesting is that when we look carefully at these things, rather than feeling ourselves at the end overwhelmed by recognition of these problems, we get a liberating sense that we are really coming to terms with what matters, we can identify with what we want to do in our lives more clearly and also the limits on what we want to do and what we can do. And we can find ethical, religious and aesthetic ways of making meaning, important meaning of the human experience that we live. O.k.? So that's what that book attempts to do through a serious of stories, because I think that if you can enter a broad conversation with people, by and large people on a subject like this are not interested in sitting down and reading a philosophical text. So I try to catch the attention of a broad set of readers I hope that will be there by writing for an educated public of non-specialists. So success to me would be not if you find my book in an academic bookstore in Vienna but if you go to Salzburg and you turn around the corner into a side street and you find somebody reading "What really matters" who has nothing to do with academia and nothing to do with medicine: that would be a success.

It is one of your most personal books and one gets the impression that it is also in a way spiritual, would you agree to that?

Well, spiritual, I don't like the word spiritual. I would say I do, there is no question about the fact that I really do need to deal with religion here and I do it in several ways. One of the cases I give is very explicitly on religion and at several times in the course of the book I deal with religious issues, including in my own life. So, I think in that sense, yes. Also I wrote it at a tough time in my career where I have won all the academic honors and had all the positions in a life, but my wife, who has been my long term collaborator, has a serious neurodegenerative disease that has made it very difficult for us. And, you know, I don't think I could have written this book if Joan and I didn't have to go through all those difficulties associated with it. And what has balanced that for me is that at 65 years of age I have also four shining grandchildren who make this an exciting time for me.

But it is a personal book and that's why I have a personal chapter. That chapter was meant to convey the idea that for a long time I had in my life a kind of sense that events outside me, circumstances and events outside me can constrain my own ethical decision making. My own morality is constrained and I give examples of that, of having done things I am sorry I did, such as for example participating in a liver biopsywhen I was an intern on someone who had died and the family didn't want to have any autopsy. I was forced by a senior professor when I was a young doctor to do that and I realized when I did it, it was the wrong thing to do. And at that time there was no outlet to talk about those kinds of things. We didn't have an ethics forum, you couldn't talk about ethics on the ward or with anyone paying any attention to you. I think I tried to indicate that all these issues that I am writing about are very important because of my own experience. And that's why I believe, what I have just said, about constrained morality being crucial for me. Values are not the only thing that counts in how we approach life: values come together with emotions – the source of the emotions can be very much in our past history, who we are, what our family life is like, what happened to us as we developed – and they come together in ways that make values something that when we feel a conflict, a threat, we get very upset, and we see that. When we see people who are very upset and you look at what's happening you often find a value issue and the philosophers I think have misled us on this point, the bioethicists included. Somehow all these decisions are supposed to be highly rational, where we sit down and we draw lists of things and compare them and work out a decision, like a work of logic, Kantian logic. I think that's a total nonsense for most people. Maybe it's true of a bioethicist, o.k., but for most people I think it's nonsense. We don't make these kind of decisions as if we were abstractly thinking about things. We have very concrete interests and we have deep feelings about things. They come together like that and I think that's one of the points I wanted to make in the book, with regard to medicine, that the medical, the moral and the emotional are very closely tied also to a degree that we have not recognized – there is also the close tie to the political as well as to the economic. In medicine today everyone recognizes the close tie of the moral, the medical and the economic but I don't think we recognize so clearly the tie to the political, that's also very important. And in that regard I tell the story of W.H.R. Rivers, but not the story of Rivers from an anthropological standpoint. I mean, I am not so interested in this account, in the fact that Rivers was a great field anthropologist who invented the genealogical method and the like, and did a tremendous work of kinship work, I am not interested in that for this book. I am interested in Rivers who came to an understanding that was anti-racist, anti-imperial and anti-war, based on very practical experiences and particularly experiences of doing psychotherapy with some of the great anti-war figures, like Siegfried Sassoon, and how Rivers himself came to an astonishing understanding, really. He began to understand that the very values that had supported his career and made him illustrious in his day, were the most dangerous values of society, and they had to be changed. Those were the values that were leading young man off to death in the First World War. And I think that was quite extraordinary.

So, look, you are writing for an Austrian audience, a German language audience, in the context of German language issues. One of the concerns that I have, highly pertinent to a Germanic world, is with the Holocaust, because I think the Holocaust is an extremely important lesson to many of us. And (in the book) I tell of an experience that I had in the east of France coming to terms with the consequences of the Holocaust for the local Jews in a French village

and my failure to understand that shortly after, only less than two decades after the Holocaust. Then was my realization that when I heard about what had happened to these French people whose graves I had visited, because I didn't have French at that time I was speaking German and I had blue eyes and blond hair when I was young and someone who didn't know who I was treated me if I were German and spoke to me as a perpetrator but I was on the side of the victims and so I heard the same thing as a victim and perpetrator together and I realized how easy it is to be a perpetrator, or if not a perpetrator, a collaborator. All of us are constantly in situations where collaboration with things we really don't want to do or believe in is possible. And how to handle that and how to work against it, recognizing the small littleness of most of our lives, certainly mine. How do you, since none is going to be a great hero, you can't call superman down, resist. You are not going to be able to do anything morally that is effective, so what can you do? So I came up with this idea, based, you know, on the antihero, of a person who can't be romanticized but who in a very realistic way disturbs and perturbs the status quo, tries to shake things up a bit, to prevent easy collaboration and is not going along with things as they are. And that ties into the final thing I would say about the book. I actually tried to come up with a theory of violence in the book, but I present it very simply: when a group feels that its values are threatened at the core, it itself becomes very dangerous and will do anything to protect its way of life and its values. And I use that as an example of what I believe again the Holocaust teaches us, that ordinary Germans were willing to make a pact with the devil, with Hitler, because they were so threatened by the Soviet Union and the fear that their way of life, their economy, their homes, all would be taken away from them. And in doing this they let the Nazis do their thing, which was the war against the Jews, because the Jews didn't matter enough to the ordinary Germans, or ordinary Austrians, to really complain about what was happening. And I think that we have plenty of evidence that ordinary Austrians and ordinary Germans were not the same as Nazi killers. They were not eliminationist antisemites but simply for them the Jews were not important enough to protect, given this other very important thing. And so I think when you look at how that happens it turns again on this idea of values and emotion. We all become very dangerous when we believe that the values and emotions most dear to us are threatened, could be taken from us, and then we will do anything to get rid of the other people. So that's more or less what the book is about. I feel that it's not the only product of this part of my career. I have a lot of other things I am doing but this has been my central work in the last few years.

So, what do you think about your future, personally, what it will bring to you?

(laughs) Well I hope I get an offer to visit Austria one day.

Yes!

I once had a fantastic experience in Austria when I was young. I was climbing in the Austrian Alps, going between these wonderful little hotel restaurants, during the summer. I had lunch and a little too much of an excellent Austrian Riesling. I got so excited by the beauty of the place that I walked out along a ledge and then fell asleep and when I woke up I realized that I was on the edge of a ledge between, you know, could fall off on both sides and I felt myself panicked in getting back to where I was. I learned something about self-control.
Well, I think for the future, I want to start another project. I have one project I am carrying with me that I should have completed years ago but haven't and I will finish now with three of my former fellows, all of whom are Chinese. I am writing a book called "Deep China – What psychiatry and anthropology tell us about the Chinese today." That looks at suicide, depression, sexuality, stigma, and a number of other things like that, so that's one thing I am carrying forward from the past, I need to get that finished. But I really am casting around now for a new project and I would like to let a year go by and keeping my mind open to things as I settle on a project, I'd like to break some new ground for myself. And also I feel, the last book I did "What really matters" was so trying, I think I need a break from the amount of time I put into suffering etc. or it will break me, so I need a little space. I am casting around still for a project. But I have a number of studies in China that are going on. One is on the health consequences of economic change in rural

China. Another one is on the experience of depression. Another one is on stigma associated with mental illness. So I have some things I am still doing but I want to open up some new space and want to think about things a little differently. I have very much enjoyed writing about W.H.R. Rivers and I think it wouldn't be too hard to try my hand on some kind of historical piece, if I can find one that is most poignant to me.

So you are in a kind of orientation in the moment?

No, I think my conceptual orientation, I don't think is changing, I am pretty secure. But in terms of where I want to dig so to speak I am not sure right now. What subject do I want to turn to. I don't see any big change in the conceptualization but I do see an empirical change and what I actually work on. I am not sure, and I would like to think about it for a while and leave it open, and I think actually leaving it open gives me a sense of liberation that I am not so hooked to the same subject forever and I can move to other things. I don't know, maybe I will write a book on happiness (we both laugh). You know, it is emotionally trying to have spent as much time on suffering as I have. I mean, three decades is a little long time and I think it has really taken its toll on me very much. I said in the acknowledgements of the book, that Max Weber, who has always been a hero for me, in 1920 I think he said, no, a little earlier, when he broke down, in the middle of his studies on Chinese society and other societies, he was asked why he was doing this, and he said he wanted to see how much he could endure. And I feel like I now know how much I can and can't endure, so I don't need to test that anymore. So I would like to cast around for other kinds of things.

Would you like to go beyond this department?

In a way I have. If I think about my career I have some parallel strengths that not everyone has. I am sure I have plenty of weaknesses, I don't need to say this in any self-aggrandizing way, but my strengths … I have both a theoretical and writing strength and I have a strength on the administry side it turns out that I never really appreciated. I enjoyed chairing the Department of Social Medicine and I enjoyed chairing the Department of Anthropology. I have one more year in chairing this department and then I have no desire to do anything bureaucratic again. I am now at an age where no dean can ask me to do anything bureaucratic, I don't have to do it and so I won't. It is the time to move beyond departments. I feel in my career, you know, there was a time I was very very active in the Department of Psychiatry, in the Department of Social Medicine, in the Department of Anthropology. Now I feel I am kind of freed up from these bureaucratic constraints. There is now one year to go and in the words of the old negro spiritual I may be able to say "Free at last, free at last, great God almighty, I'm free at last." And I will be able to do my own thing, that starts in July of 2007.
Years ago I was asked to be President of a university, I don't want to be President of a university, I don't want to be the head of a foundation, those are not things I would enjoy doing. I am your basic academic. I like to read and write and do research. That I need a break and that I need to think through what new research I can do, that will be interesting to me. And actually I feel now that I am at a stage of my life where I am probably looking at best at my last ten years. So I am 65, I am sure by 75, if I am still alive, I will be nearing the very very end of my career and so, what do I want to do at this stage, of the last ten years?

Where do you think does Medical Anthropology go at Harvard? There are many changes going on…

Many changes, so Jim Kim, who is a former student of mine, becomes the Chair of the Department of Social Medicine, so we have yet another medical anthropologist running the Department of Social Medicine. I think Jim and Paul Farmer strongly defined medical anthropology at the medical school as organized naround infectious diseases. I think that's important. I think that on this side of the river (in Cambridge), I am not sure exactly where medical anthropology is going. I mean at some stage they will have to replace me over here when I retire. Byron, although he has done a lot of work on this side of the river, has never had an appointment in anthropology, he wouldn't be replaced in any way. We have a young medical anthropologists, her name is

Kimberly Theidon, she works in South America on violence. She has got this very excellent set of issues around violence, especially political violence and its consequences and trauma etc. We are hiring right now an anthropologist of science, so I could see that going on, and then there would be an anthropologist who works on one of the important themes in biotechnology. I am sure that a number of my former students will be candidates for my chair, when I retire. But I am very robust about medical anthropology at Harvard because we have had an enormous growth in students. You know, this year to the MD Ph.D. program alone, we had nine people apply, nine people who could apply simultaneously to the MD and the Ph.D. side and be competitive on those two sides, that is astonishing. And very impressive to me, they are coming along from very different universities. I have a terrific group of graduate students moving through, finishing up. We have lots of undergraduates interested in this. So I think medical anthropology is in a very good situation and I think the university sees it as important part of what the university is about. So it's going to be protected in the future. I think medical anthropology as we do it, in a broad sense, is going to become increasingly interesting in European settings. I just received the e-mail today from Annemiek Richters in Holland who told me that at her university, Leiden, that they are going to build medical anthropology more, so that's wonderful to hear. Amsterdam already has that. I have been told by a number of people that there is an interesting set of developments in Germany, that for the first time German universities are becoming really serious about some of this. So maybe we see some interesting changes. This much I can tell you that if anthropology is to survive, which I believe it will in the future, medical anthropology is going to be a strong part of that. Because medical anthropology 30 years ago was on the margins of anthropology but today it's smack in the center and what probably most people in your society and my society actually know about anthropology today is coming from medical anthropology. So I think you are going to see medical anthropology do pretty well in the future. In mean academically. Whether medical anthropology will be effective in the world remains to be seen. Jim has done some important things, Paul certainly has; there are a whole bunch of medical anthropologists working in the field of very practical public health international development projects. We have to see what comes out of that. And that means that a lot of medical anthropologists in the future won't be centered in the university; they will be in international agencies etc. And so what story that will tell, I have no idea.

What do you think will be the major themes?

Well, clearly infectious diseases will be, social inequalities, particularly looking at infectious diseases and other sources of child and adult mortality. I think mental illness will stay an important theme because of how poorly the mentally ill are treated around the world. That this will stay an important theme. I think the anthropology of science is going to be one of the leading edges of medical anthropology, and you can see more and more anthropologists working on genomics, on biotechnology etc., on global pharmaceuticals, that's going to be where a lot of research is going to go. I think that medical anthropology will always have a side that's close to religion because the anthropology of religion and the anthropology of medicine have always shared an area and that will keep them close together, around meanings, around the kind of things I was writing about here. I think that you'll see a new generation of medical anthropologists who take the violence story in a different direction. Violence largely has been taken into the direction of trauma; I think there is a new set of stories about violence that will go not so much in a trauma direction but will go into those things that either prevent recurrent political violence or that have to do with reconciliation and humanitarian assistance. I think the connection between anthropology and humanitarian assistance will become much closer. I think we have already seen medical anthropologists spend greater time on ethics, so I think in the ethical domain you will see more medical anthropology. So, you know, it is a very different field than when I got into it. When I was here at Harvard in 1970, 36 years ago, starting my anthropology, there was no medical anthropology at Harvard, there was no tradition of medical anthropology, there were no courses, there were no students. So as I look back it's pretty fantastic to see that in 36 years things have really changed considerably. And it will be fun to see in the next 20 years where the field goes. I think my former student and now

colleague Paul Farmer has had a fantastic impact in his own life story particularly on young American students, not just medical students, students in lots of fields who want to do the same kind of things that Paul does. And I think a lot of that interest is not really an academic interest. I think a lot of that interest is a very applied interest to do important things in the world. And I think a lot of medical anthropology in the future may go way beyond the academy. I wouldn't be surprised to find in America in the future medical anthropology taught at the high-school level, seriously! I have high-school students coming and saying they want to learn this, they should be learning this field in high-school. It is interesting, I never thought about, never thought about that in the past.

So what do you think about the new curriculum medicine which is developing now?

I think medicine is changing in response to tremendous challenges. In America, I don't know how the situation in Austria is, but in America we have a totally broken health care system. We are now collapsing, spiraling down till we are going to hit bottom at some stage, where the whole system just breaks apart. In the classical American tradition, when we are just one second before that happens, something will be done at the national level. That's the way we deal with crisis in this country. We let them spiral, spiral, spiral and when we get to the point that something must be done, it gets done, but usually it gets done in a short sighted way that is a stop-gap for a period of time and it doesn't ultimately solve things. I think you will see that with the American health care system, that there won't be changes. And within that, teaching about culture, about ethics, about the human side of medicine, what I call the medical humanities, I think that will become much more important in medical school. So we are just starting at Harvard now a program in the medical humanities that brings together different fields.
In medical school they are teaching some of that but how they teach it is still not fully worked out.

So what do you think about medical anthropology or the medical humanities being a mandatory subject for medical students?

I think it's a good idea, if it's properly taught. I think if it is properly taught you would want to reach over to the Arts and Sciences Faculty at Harvard to have some of our great humanists teach the medical students. I think that would be terrific. The Medical School would have access to some of the really great figures in literature, in arts, in history, in anthropology and that would supplement The Medical School's own faculty. All could be done by a Department like Social Medicine. We are here a huge Faculty that spends all its time teaching undergraduates and graduate students but could also teach medical students. And I think we are seeing the opposite effect as well, the Medical School Faculty is coming down to teach undergraduates and our undergraduates want to have secondary fields in something like global health and they are going to be able to do that in future, I am sure.

Thank you for the interview.

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Book Review

Jeremy Ross: Westliche Heilpflanzen und Chinesische Medizin. Kombination und Integration. Die Anwendung 50 westlicher Heilpflanzen entsprechend westlicher Tradition, chinesischer Medizin und Phytopharmakologie. 2006, Verlag für Ganzheitliche Medizin Dr. Erich Wühr GmbH, Bad Kötzting.

Jeremy Ross' new book is an extensive and elaborate work that deals with the combination of Western herbs and Chinese medicine. In writing the book the author pursued four aims: " (…) to summarize the empirical data on herb use from contemporary Western texts, to classify Western herbs in terms of Chinese values for temperature, taste, actions, and organs entered, to apply the Chinese principles of herb combination to Western herbs, and finally to give illustrative combinations for each herb discussed." (Ross 2006, preface)

When I first heard of the book – without having seen it – I thought to myself, "What, only 50 herbs? That doesn't seem much compared to the huge Western materia medica!". But when I finally held the book with 984 pages in my hands I knew why the author decided to discuss "only" 51 herbs thoroughly! In addition to herbs that have their own chapter, there are brief descriptions of 66 more herbs because they are part of the combinations discussed in the book. The discussion of the particular herbs covers an average of 15 pages each, and thus the author limited the number of herbs treated in this degree of detail. His choice of herbs reflects the author's personal background and preferences, but also represents different areas and indications. He included several herbs native to North America, such as *Asclepias tuberosa*, *Hydrastis canadensis*, *Lobelia inflata*, *Myrica cerifera*, *Phytolacca americana*, and *Zanthoxylum* species. These herbs represent the important contribution of the Native American people and of the Physiomedical movement to herbal therapy. They are well known in Britain, but are still little used in Europe. The author has also included several aromatic herbs native to the Mediterranean region, such as *Lavandula angustifolia*, *Rosmarinus officinalis*, *Salvia officinalis*, and *Thymus vulgaris*. Their aromatic constituents can affect both emotional and mental state, which has made these herbs central to the development of aromatherapy. They are little known in China, and *Lavandula* and *Rosmarinus* have been much more commonly used in Europe than in the United States. Furthermore the author has included several herbs that can be used to treat cardiac disorders such as cardiac weakness, cardiac arrythmias, and angina pectoris. Among them are *Cinchona* species, *Convallaria majalis*, *Crataegus species*, *Leonurus cardiaca*, and *Sarothamnus scoparius*. Wherever possible the author gives references to source material for his statements, and over 1,500 references have been cited.

The book is divided into two main sections: *Herbal medicine in theory and practice* and *Materia medica*. In the first section the author discusses history, temperature, taste, actions, principles of herb combination, practical herb combination, dose, safety, safety and the organ systems, and safety in clinical practice. In the chapter *History* the reader learns about three of the most influential founders of Western herbal medicine, that is to say Hippocrates, Dioscorides, and Galen. The chapter deals with the influence of scholars and movements onto the development of the Western pharmacopoeia and phytotherapy beginning from ancient Greece and ancient Rome and ending with the 20th century. The author explains the development of the four elements (fire, air, earth and water), the primary qualities (hot and dry, hot and moist, cold and dry, cold and moist), the humors (yellow bile, blood, black bile,

and phlegm) and the temperaments. It is interesting to read that the similar theories of the Western four elements and Chinese five elements should arise within about one century of each other in Greece and China, respectively.

The author discusses the influence and importance of Aristotle and Theophrastus of Eresos; Dioscorides whose excellent work remained the standard text until the 16th century and even then, his work was regarded as authoritative and was continually quoted by later herbalists; Pliny whose contribution was more to botanical terminology, than to herbal medicine; Galen of Pergamon who described each herb in terms of temperature (whether warming or cooling) and moisture (whether drying or moistening), and the body parts on which the herb acts; the influence of Islamic physicians in the middle ages such as Rhazes and Avicenna who greatly enlarged the range of herbs by the Greeks and Romans in adding many medicinal plants from North Africa, Arabia, and Persia, and herbs and spices from India and the Far East; and Christian herbalists like Hildegard von Bingen; the influence of Brunfels, Hieronymus Bock and especially Tabernaemontanus in the Renaissance; Gerard, Culpeper and Linnaeus in the 17th and 18th century; the development of the Physiomedical and Eclectic movements of American herbal therapy and scholars such as Thomson, Lyle, Felter & Lloyd in the 19th century, and eventually the National Institute of Medical Herbalists and the influence of Chinese herbal medicine, and phytopharmacological research in the 20th century. Ross also notes the importance of uneducated herbalists throughout the ages whose knowledge of herbs came from oral tradition and personal experience, (the only herbal medicine available to the majority). This folk knowledge may often have been recorded in writing by more literate colleagues and formed an important source for both medieval and Renaissance materia medica. Dioscorides was the author of the first Western materia medica that was both thorough and practical. Thus it became the most influential materia medica in Western history. The indications that Dioscorides provided for individual herbs have been copied in subsequent herbal texts right into the 20th century.

For me as a CM-specialist it was very interesting to read about the classification of Western herbs and how it developed. Galen's system of classifying and using herbs according to properties and actions was used in the West for 15 centuries and provided a theoretical structure in herbal medicine similar to that used in the Chinese medicine tradition.
Ross states that according to Hippocrates health depended on a proper balance of heat and cold, and dryness and moisture. If a person had a disorder involving heat and dryness, this would be balanced with food or herbs that were cooling and moistening. This concept of polar opposites was later used by Galen as the basis for his systematic classification of herbs according to the herbs' properties. Galen of Pergamon (130-200 AD) classified herbs according to nine temperature categories: temperate, hot in the first to the fourth degree, and cold in the first to the fourth degree. Hildegard von Bingen used a less structured classification, including the categories of very hot, hot, slightly hot, neither hot nor cold, cold, and very cold. Her system is closer to the Chinese system than to that of Galen.

Ross is using the five Chinese temperature divisions – hot, warm, neutral, cool and cold, and sometimes uses slightly warm in addition when it is needed, which is somewhere between warm and neutral. However, in assigning temperature values for herbs discussed in this book, he has weighed traditional Western and traditional Chinese sources, pharmacological and clinical research, and his own personal experience. I cannot agree with all the temperature qualities he has assigned to particular herbs. Moreover I believe that what he says regarding the taste of an herb – that it is important and "valuable for practitioners of herbal medicine to taste and take the herbs that they use to compare the effect of the theoretical taste properties with its taste in the mouth and with its effects on their own bodies" – that this also applies – even more! – to the temperature quality. For example from my own experience and experiment I believe that *Gentiana lutea* is (really, really) cold, however Ross states it to be neutral-cool. All Western herbalists cited by Ross have classified *Gentiana* as a warm drug, although it has also been used to treat heat patterns, such as fever. In my opinion it was classified as warm because of its drying effect, it can injure the body fluids which can lead to a secondary warm perception.

In his book Ross introduces a concept of variable herb temperature which at the beginning I found

really strange, especially because I read the chapter about *Achillea millefolium* first, which is categorized as being warm-cool whereas in my opinion it is cool, even slightly cold so I have never recommended it to persons with spleen-deficiency accompanied by loose stools. But with his arguments Jeremy Ross has awakened my spirit of research again. He states amongst other arguments that the different effects of *Achillea* "may be linked to different constituents: the chamazulenes and prochamazulenes may be involved in a cooling effect and camphor may be involved in either cooling or warming effects, depending on the situation". The latter ("depending on the situation") makes me doubt again just like his argument that " (…) the effect of *Achillea* may depend on the needs of the body: if there is a hot condition, this may evoke a cooling effect; if there is a neutral condition, neither a cooling nor warming effect may be evoked; whilst if there is a cool condition, this may evoke a warming effect". But although I do not find this concept completely convincing I sure find it interesting and worth of examination.

What I find very useful are the Western and Chinese actions and how they correspond with each other, also described in the chapter *temperature*: for instance the reader learns that hot herbs act as metabolic stimulants, circulatory stimulants, warming diaphoretics, warming antirheumatics, and counterirritants in terms of Western effects. The corresponding Chinese actions are: tonify Yang of kidney, heart, or spleen (metabolic stimulants), warm and move Qi and blood (circulatory stimulants), clear Wind-Cold-Damp (warming diaphoretics), clear Wind-Cold-Damp and warm and move Qi and blood (warming antirheumatics), and topical irritant (counterirritants). Warm herbs that are used as warming tonics in Western terms tonify Qi and Yang in Chinese terms, carminative (Western term) herbs move Qi of spleen and intestines, and those used as warming expectorants (Western term) clear lung-phlegm-cold in Chinese terms. Ross is "translating" all Western actions into Chinese actions wherever possible. In this chapter he already starts with caution and safety instructions regarding hot and cold herbs, although later on there are three chapters only dealing with safety in particular covering aspects such as the risk of adverse herb reactions, the importance of multiple active constituents, the quality of herbal practitioners, the risk-benefit-ratio, and safety regarding the organ systems such as hepatotoxicity.

In this first section there is a larger chapter that deals with Chinese and Western concepts of taste. The reader learns that in Galen's system of herb classification, there was less emphasis on the taste property than in Chinese herbal medicine. More recently in Western herbal medicine, individual taste sensations have been associated with specific herbal effects, e.g. the bitter with the digestive tonic action and aromatic with the carminative action. Ross explains the effects and actions of the five relevant tastes bitter, sweet, sour, acrid, and aromatic thoroughly and discusses them from a Chinese, Western and biochemical aspect, and again combines the Western and the Chinese perspectives, and thus provides the herbal therapist a very broad and useful range of practical and clinical information. Further on there is a chapter dealing with the classification of herbs by its actions including tables with Western and Chinese actions and herb examples. The lesser trained reader will be glad to find an elaborate *Actions glossary* right after this chapter, where he/she will find an explanation of all actions from adaptogens and alteratives to vesicants and vulneraries. There are also cross-links between German and Latin terms, such as "antipyretics" and "fiebersenkende Mittel".

In the second and main part of the book, the *Materia medica*, each chapter is devoted to a single herb, and over 150 different herb combinations are described and discussed, and most of them derive from the author's own experience. For the others the appropriate references are cited. The Materia medica can be used for an in-depth study on a particular herb and/or as a reference text for finding specific information. Each materia medica chapter is organized in different sections: the introduction provides information such as names (botanical, family, pharmaceutical, English, German, French, and Mandarin), part of the herb which are used, the use in the West, and the use in China. Under the section *What is special about the herb* Ross discusses properties and meridians, the key to understanding the herb, Chinese actions, Western actions, Western uses, direction of energy, and typical case example. The section *Limitations of the herb* deals with temperature, taste and actions. Then the author gives examples of herb pairs including that herb, individual combinations and comparison of combinations. Under the section *Research* constituents, pharmacological and clinical research, research verification

of traditional actions as well as toxicology are discussed. This is followed by the sections *Dose*, *Cautions* and *Regulatory status*. Each chapter is ends with a discussion of *Traditional sources* and *References*.

To illustrate, I would like to outline one herb briefly:
Arctium lappa L. (A. majus Bernh.) or *A. minus* Bernh. belongs to the family of Asteraceae (Compositae), its pharmaceutical name is Arctii radix (Bardanae radix or Lappae radix), the English name is burdock, the German name is Große Klette, the French name is bardane and the Mandarin name is niu bang gen (roots of *A. lappa* L.), niu bang zi (semen of *A. lappa* L.), and the part used is the air-dried root. In terms of Chinese medicine, *Arctium* clears wind-heat and retained pathogen (for treating acute throat conditions with fever, and removes rashes) – which corresponds with the Western action as being alterative and a dermatological agent, it clears heat-toxin which corresponds with being alterative, anti-inflammatory, dermatological agent, and antiarthritic in Western terms, and assists the kidney and bladder to drain dampness which corresponds with being diuretic, urinary anti-inflammatory and alterative in Western terms. The main Western uses are recurring urticaria, allergic eczema, eczema, psoriasis, acne, boils, arthritis, rheumatism, gout, lymphadenitis, adjunct to cancer therapy, and as a secondary herb for cystitis or obesity with edema. Fortunately all this information is clearly laid out in tables. *Arctium* root is classified as slightly bitter because it acts as a mild inflammatory and also a mild bitter tonic for the digestive system. It is classified as cool by the author, and is appropriate for warm conditions, although it can be used for hot, neutral or cool conditions if it is suitably combined with other herbs. Ross states that *Arctium* is an herb which is best used in combination with others, rather than as a single herb. After explaining the diaphoretic, alterative, diuretic, laxative, and tonic actions of the herb the author discusses the actions and indications of *Arctium* paired with other herbs, that is to say *Ephedra*, *Urtica*, *Mahonia*, *Harpagophytum*, *Taraxacum*, *Iris*, *Rheum*, *Scrophularia*, *Smilax*, *Viola*, *Phytolacca*, and *Baptisia*. In the following pages six *Arctium* combinations are discussed thoroughly. The six indications are (the correlating Chinese syndromes in brackets): recurring urticaria – acute phase (wind-heat and retained pathogen), recurring urticaria – remission phase (retained pathogen and blood-deficiency), chronic eczema (damp-heat and blood-deficiency), acute psoriasis (blood-heat and heat-toxin), arthritis and heat sensations (damp-heat in the channels), and cancer therapy adjunct (Qi-stagnation, damp-heat and heat-toxin).
I want to give one example of a combination, the cancer therapy adjunct combination (the number in brackets is the ratio): "Thuja (1), Viola odo. (1), Phytolacca (1), Hydrastis (1), Taraxacum (1), Arctium root (1), Glycyrrhiza (0.5), Zingiber (0.5). [These are mainly] alterative herbs that can help to clear retained pathogen, damp-heat, and heat-toxin, thus, helping to reduce the side effects of radio- or chemotherapy. Glycyrrhiza can assist detoxification and act as an anti-inflammatory and a tonic. Zingiber moderates the effects of the cooling herbs and helps to stimulate circulation and digestion."

The last chapter of the *Materia medica* deals with additional herbs that are used in the combinations throughout the book. This chapter mainly presents a table with the herbs, properties, dosage, contraindications, and indications.

At the end of the book the reader will find several elaborate and useful indices and cross references:
Herb properties: here the reader finds the botanical herb name, temperature, taste and organs on which the herb acts.
Herb names: here the reader finds the botanical name and parts used, the pharmaceutical, German, English, and French name.
Herb index with the following cross references:
Family – botanical names: the family name is given in Latin and German.
Botanical names – family: the family name is given in Latin and German.
German – botanical herb names: here the reader finds the German, the botanical name and the page to be found in the book.
Pharmaceutical names – German: here the reader finds the pharmaceutical and German names, parts used and the page to be found in the book.
Botanical names – Mandarin herb names: here the reader finds the botanical and Mandarin names, the Chinese characters (!) and page where to be found in the book.

Mandarin – botanical: here the reader finds the Mandarin and botanical names, the Chinese characters (!) and page where to be found in the book.
Combinations – Chinese syndromes: here the reader finds the herb name, the Western indication, the Chinese syndrome and the page where to be found in the book.
Disorders – combinations: here the reader finds Western symptoms and diseases, the applied herb and the page where to be found in the book.
Index: it is organized by herbs, herb actions, disorders and Chinese syndromes.

There are some disagreements regarding the energetic properties of particular herbs, as I mentioned above. Ross, for instance, states that the key to understanding *Calendula officinalis* is that it is a bitter herb that can have antimicrobial, alterative, anti-inflammatory, astringend, and vulnerary actions. From my experience the dried *Calendula* flower taste bitter and slightly acrid, but an infuse of the blossoms tastes slightly sweet and not bitter at all. I agree with all the actions that Ross ascribes to *Calendula*, but also, in addition *Calendula* is the most important Qi-moving herb of the West and can be used as a substitute of the Chinese herb Radix Bupleuri (Chai hu). Another example is *Rosmarinus officinalis*. Ross explains that the herb calms liver-hyperactive-Yang to treat headache, but in my opinion *Rosmarinus* is much too warm to calm liver-Yang. I am convinced that *Rosmarinus* helps against headaches that are caused by dampness in the liver channels so that Qi and blood cannot reach and supply the head. *Rosmarinus* dries the dampness in the liver channels which gives way to the free flow of Qi and blood again. Or let's take *Thymus vulgaris* L., it is assigned as having cooling and warming effects by the author. From my experience it is very warm and drying (as the author states that also Hildegard von Bingen, Gerard and Tabernaemontanus share the same opinion) and therefore contraindicated in the case of Yin-deficiency when given alone, and it even can increase hot phlegm in persons with lung-Yin-deficiency.

Although I sometimes do not agree with Ross' classification of the particular herbs I still think that this is a great work combining traditional Western herb medicine, Chinese phytotherapy tradition, modern biochemical research and the author's personal experience.
It serves not only as an excellent textbook for less experienced physicians, practitioners, and students of Chinese and/or Western herbal medicine, but it is also a tremendous benefit to the knowledge of advanced Chinese medical specialists. The book's purpose is to provide the reader with the following information: "[…] a clear differentiation between the different herbs presented, a framework for theoretical principles as a basis for herb choice and herb combination, to initiate an integration in the use of herbs according to Western tradition, Chinese tradition, and modern research, […] suitable herb combinations to illustrate the use of each main herb presented, and […] the importance of safety considerations in herbal medicine". In my opinion Jeremy Ross succeeded in fulfilling this purpose in all areas.

Maria Michalitsch

Forthcoming Conferences

The 10th International Congress of Ethnobiology (ICE): „Ethnobiology, Biodiversity and Community Development“. Chiang Rai, Thailand **November 5-9, 2006**
http://botany.kku.ac.th/ice2006/index.php
International Congress of Ethnobiology in Ethnobiology and Community: Food, Health and Cultural Landscapes, Hosted by: Khon Kaen University and the International Society of Ethnobiology.

Society for the Anthropology of Consciousness 2007 Spring Meeting. San Diego, CA, USA, **April 4-7, 2007, in San Diego, California, USA.** Theme and venue TBA. For more information, visit www.sacaaa.org or write to johnbaker@vcccd.net (SAC President)

New Trends in Ethnobotany and Ethnopharmacology, Joint Meeting: 20th Conference Ethnomedicine & 6th European Colloquium on Ethnopharmacology
The meeting will be held in the Museum für Völkerkunde, Grassi Museum, Leipzig (Germany) from **May 10 - 12, 2007** under the auspices of the European Society of Ethnopharmacology (ESE).
AGEM (Arbeitsgemeinschaft Ethnomedizin) in co-operation with the European Society of Ethnopharmacology – ESE http://ethnopharma.free.fr / Société Francaise d'Ethnopharmacologie – SFE www.ethnopharmacologia.org / Austrian Ethnomedical Society – ÖEG http://www.univie.ac.at/ethnomedicine
Themes
1) Skin and wrapper: dermatology, cosmetics and prevention
2) Humans and animals: from ethnozoology and veterinary medicine to the construction of the bird flu
3) Ethnomycology: inventory of non-hallucinogen mushrooms and other chitin-containing substances (e.g. insects.)
4) Toward an Anthropology of medications
5) Ethics and international rules for an applied ethnobotany and an applied ethnopharmacology: How do we value traditional knowledge?
6) Posters concerning all topics related to ethnobotany and ethnopharmacology are welcome
Contact and further information
6th European Colloquium of Ethnopharmacology, c/o Ekkehard Schröder, Spindelstrasse 3,
D-14482 Potssdam, Germany, Tel.: +49 331 704 46 81, Fax: +49 331 704 46 82,
e-mail: ee.schroeder@t-online.de

1st circular of the conference **Charms, Charmers, Charming** to be held in Pécs (Hungary) **May 11-13, 2007**, organized by the ISFNR Committee on Charms, Charmers and Charming, the Department of Ethnology and Cultural Anthropology, University of Pécs, the Folklore Society, London, and the Hungarian Ethnographical Society.

The **8th Conference of the International Society for Shamanistic Research** (ISSR) will be held in Hungary, on **June 2–9, 2007**. The central themes of the conference will be:
(1) The Revival or Continuation of Shamanism
(2) Visual Presentation of Shamanic Rituals
(3) Shamanhood as Means of Identity of Minorities
The attendance fee for the conference will be approximately ?200-250. Titles of papers and abstracts of max. 200 words should be sent to the Organizing Committee by October 31, 2006. Authors can email these to *hoppal@etnologia.mta.hu*
The presentation time for papers will be limited to 20 minutes. The working language of the conference will be English. For further information, please visit our web site at *www.etnologia.mta.hu*
Address for correspondence: Mihály Hoppál, Institute of Ethnology, Hungarian Academy of Sciences, Budapest, Pf. 29., Hungary, H-1250
Phone: +36 1 224-6781, Fax: +36 1 356-8058

The search for new plant-based therapy. 48th Annual meeting of the Society for Economic Botany, Chicago, Illinois, USA, **June 4-7, 2007**. Chicago Botanic Garden, The Field Museum, University of Illinois at Chicago and Northwestern University.
http://www.econbot.org

International Conference on Traditional Medicine and Medicinal Plants: "Women's Health and Traditional Medicine", **September 2007**, Surabaya, Indonesia, Indonesian Association of Researchers on Natural Products Medicine (PERHIPBA), Surabaya Private University, Airlangga State University and Widya Mandala Catholic University.

First International Congress on Ethnomedicine and Ethnopharmacology of European Countries, October 5-6, 2007, Vinci, Italy. Center of Natural Medicine, S.Giuseppe Hospital, ETM 2007 European Traditional Medicine www.medicinanaturale.usl11.tos.it/dati/etm%202007.pd

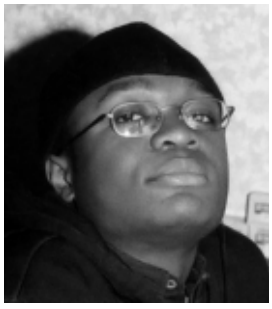
Contributing Authors

Rainer Brandl MD, General Practitioner, volunteered since he was a teenager in programmes dealing with rural population in South Korea, India and Tanzania. He is currently leading a HIV/AIDS treatment and prevention Programme of the Austrian Evangelical Association for World Mission in Tanzania.

Paul Bukuluki, BA (SWSA), MA (Med. Anthropology), PhD Candidate at the Unit Ethnomedicine, Center for Public Health, Medical University of Vienna.

Gerhard Kubik, PhD. (University of Vienna 1971), cultural anthropologist, ethnomusciologist, psychoanalyst, field research in African countries since the early 1960s; lecturer at the University of Vienna; Sigmund Freud University Vienna, University of Klagenfurt

Moya Malamussi, Ph.D. (University of Vienna 2004), cultural anthropologist, founder of the Oral Literature Research Program in Chileka, Malawi. He has lived in Vienna since 1984.



Yohana Malamusi, student in Communication Studies at the University of Vienna, accompanies his father Moya on many field trips.

Photograph last page

The traditional Malawian healer Mai Stamidya Stafford. In her therapy sessions, she is acting in a trance-like state, first identifying a patient's problems in her consulting room, then acting out symbolic solutions in spectacular dramatic performances in front of onlookers outside her house.

Mai Stamidya Stafford

A-1090 WIEN · WÄHRINGERSTRASSE 25 · AUSTRIA · TEL ++43(0)1/427763412 · FAX ++43(0)1/42779634