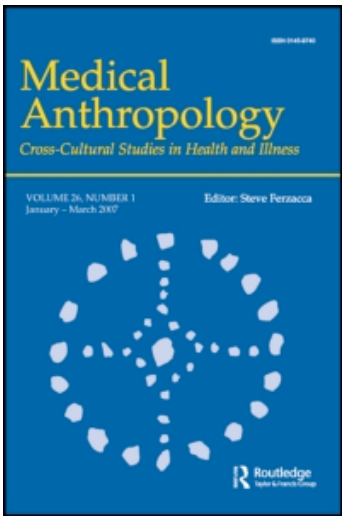

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ARTICLES

Reconsidering the Allure of the Culturally Distant in Therapy Seeking: A Case Study from Coastal Tanzania

Vinay R. Kamat

This article examines two seemingly contradictory notions found in the anthropological literature that address so-called traditional healers. First, it suggests that despite their purportedly holistic approach, healers in coastal Tanzania may not be as popularly sought after by "local" people as they are made out to be by some academics and health policy researchers. Second, it contends that although there may be a tendency among the people of Tanzania to consult "distant" healers for social relationship–related conditions, the decision-making process involved in seeking out such healers is far more dynamic and context dependent than has been previously reported in the literature. People who seek help from distant healers have often unsuccessfully tried locally available health care resources. In making these arguments, I draw on ethnographic data gathered in a large village in the Dar es Salaam region of coastal Tanzania. In particular, I examine the divinatory

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practices of a well-known Zaramo healer (*mganga*) and discuss narrative case studies of two patients who had traveled from distant places to seek the *mganga*'s help. The article concludes with a call for the critical reevaluation of propositions for the integration of "traditional healers" in programs aimed at the prevention and treatment of life-threatening infectious diseases that are predicated mainly on the assumption that healers are popular among the local people and provide effective consultations.

Key Words: ethnography; Tanzania; therapy seeking; traditional healers; Zaramo

Ethnographic accounts of healing practices in the East and Central African region have commonly emphasized the ability of so-called traditional healers[1] to attract and successfully heal their patients (cf., Chavanduka 1978; Feierman 1985; Gelfand et al. 1985; Good 1987; Janzen 1978; 1992; Makemba et al. 1996; McMillen 2004; Prince and Geissler 2001; Rekdal 1999; Swantz M. L. 1979; 1989; 1995; Turner 1968; Whyte 1989; 1997; Winch et al. 1996). Scholars have suggested that the success of these healers in their practices often stems from the social and cultural backgrounds they share with their patients, the personal relationships they establish with their clients, and the holistic approaches they employ toward illness and suffering (Feierman and Janzen 1992; Gessler et al. 1995; Green 1988; Katz and Kimani 1982; Swantz L. 1990). Van der Geest (1997: 907) for example, stated, "the fact that healers and patients share ideas about the origin, meaning and preferable treatment of illness [itself] enhances the efficacy of treatment." Similarly, in summarizing aspects of the popularity of healers as put forth by numerous Africanists, Rekdal (1999: 466) noted:

> [T]he patient is treated not primarily as an individual, but an integral part of a social and cultural whole. The activities of the traditional healer are frequently described as "family therapy," "group therapy," "community healing" . . . and "collective therapeutic rites" [are regarded] . . . as one of the distinctive characteristics common to African therapeutic traditions.

Over the past few years, however, anthropologists have reconsidered the popularity of traditional healers in Africa, pointing out that those in search of therapy often neither participate in collective therapeutic rites nor consult healers living in their vicinity (cf., Beckerleg 1994; Swantz 1979; Whyte 1997). Instead, they seek out well-known healers who live in far away places and with whom they *do not* share a common social and cultural background. In such situations, patients are better able to remain discrete about their affliction or misfortune and take therapeutic actions without being under the gaze of their neighbors or potential enemies (cf., Brodwin 1992; Evans-Pritchard 1976; Pfeiffer 2002; Rekdal 1999; Swantz 1990; Whyte

1997). As Rekdal (1999: 468) put it, "diagnosing the cause of illness, which in Africa is so often linked to interpersonal relations within the local community, requires the objectivity and impartiality characteristic of the stranger," because "only strangers can guarantee anonymity in the consultation of folk practitioners" (Amuyunzu 1998: 500).

In illustrating this point, Rekdal (1999) reported that in his quest to understand Iraqw illness concepts and health-seeking behaviors, his key informants did not turn out to be Iraqw but rather, members of other ethnic groups. Many of the healers did not speak any Iraqw and had limited knowledge of Iraqw culture. Along the same lines, Whyte (1997) noted that the three diviners she worked with in Uganda did not divine in their own neighborhoods. In fact, some of their clients traveled considerable distances for consultation. The diviners confronted people about whose background and current situations they knew little or nothing. Exploring a similar pattern within a broader political economy and historical framework, Sanders (2001) argued that in Tanzania the practice of moving across geographic and cultural boundaries or ethnic groups in search of therapy has been accentuated by the rapid social and economic transformations engendered through the neoliberal market reforms promoted by the World Bank and International Monetary Fund (IMF). In particular, he noted that the clients of a well-known Ihanzu diviner he worked with came from several hundred miles away. Additionally, many of these clients were well-educated and economically and politically important people. Finally, in a recently edited collection of ethnographic case studies from southeast Africa, Luedke and West (2005: 2) suggested that most "local" healers actually seem to come from elsewhere. In Mozambique, specifically, the most respected "local" healers were either born across the border in Tanzania or claimed to have learned their vocation there. Apparently, healers are often judged more powerful on "the other side of the border."

In this article, I critically examine the popularity of "traditional healers" in coastal Tanzania and show that the decision-making process involved in seeking out healers is far more dynamic and context dependent than has been previously reported in the literature. I draw upon ethnographic data and case material on misfortune and therapy seeking gathered during 16 months of fieldwork in Dar es Salaam, Tanzania, examining in particular the divinatory practices of Mzee Tinyango,[2] a ritualist-herbalist (*nyinginezo na mitishamba*) Zaramo *mganga* (plural *waganga*) with whom I worked closely for about eight months. I also draw on narrative case studies of two patients who had traveled from distant places to seek the *mganga*'s help to illustrate the intricate decision-making process involved in seeking out distant healers. I conclude by emphasizing the need for a critical reevaluation of propositions for the integration of "traditional healers" in the prevention and treatment of life-threatening infectious diseases such as

HIV/AIDS, malaria, and tuberculosis, as these proposals are predicated on the debatable assumption that healers throughout Africa are popular with members of their own community and that they provide therapies that are culturally appropriate and acceptable to a vast majority of the population (cf., Abdool Karim 1994; Bannerman et al. 1983; Green 1999; Homsy et al. 2004; Kayombo et al. 2007; Makemba et al. 1996; Mills et al. 2006; Pigg 1995; 1997: Semali 1986; van der Geest 1985; 1997; Ventevogel 1996; World Health Organization (WHO)/UNICEF 1978; Wilkinson et al. 2001, Winch et al. 1996).

RESEARCH SETTING AND METHODS

I carried out fieldwork in Mbande, a relatively large village of some 5,500 residents located on the periphery of Temeke District, Dar es Salaam. Mbande came into being in 1974 during *Operation Vijijini* (also known as villagization) (McHenry 1979). The people of Mbande share a common history with hundreds of other villages that were started during *Operation Vijijini* by way of regrouping households into larger units in the spirit of *ujamaa* socialism, or "familyhood" (Hyden 1980). The village does not have electricity and has only recently benefited from a safe drinking water project implemented by a U.K.-based nongovernmental organization (NGO). Of the 95 percent of the local residents who are Muslim, 40 percent identify themselves as Zaramo, the original inhabitants of Dar es Salaam (Swantz 1979; 1995; Tripp 1997). Subsistence-oriented farming comprises the economic base for the majority of the local people, while a small proportion of villagers engage in small businesses such as the selling of peanuts, bread, tea, fruits, and vegetables in the marketplace. For most, cash income is scarce—the average per capita, per month cash income is approximately Tsh. 1475 ($2). Thus, in everyday conversations about the government's decision to "free the market" as part of neo-liberal economic reforms, one hears the common refrain *maisha magumu*, meaning life has grown increasingly intolerable (Kamat 2008). The local health arena is pluralistic because villagers have access to "Swahili" medicine, biomedicine, and pharmaceuticals. Located five minutes away from the marketplace is a municipal dispensary that was originally built in 1976 and refurbished in 1997. It is staffed by a medical officer, three nurses (two of whom are mother and child health (MCH) specialists), and a trainee nurse. Also within the village are three privately owned pharmacies (*duka la dawa*), all of which are operated by unqualified pharmacists who offer a range of medications, including antibiotics, to their clients over the counter. There are four known *waganga* who reside in the village as well. However, only one of them, Mzee Tinyango, who features prominently in this article, practices on a full-time basis.[3]

During the first few weeks of my fieldwork, I noted that the village-level health arena was medically pluralistic to an almost idyllic extent given the local people's access to a newly refurbished municipal dispensary, three relatively well-stocked private pharmacies, and four *waganga*—a Zaramo, a Ndengereko, and two Matumbi. To the casual observer, the people of Mbande did not have to go very far in search of therapy. However, as I became immersed in fieldwork, I learned that very few people in Mbande actually consulted the *waganga* who were practicing in the village. Data from participant observation, interviews with the *waganga* and a sample of 25 of Mzee Tinyango's patients,[4] informal conversations with elderly key informants in the village, a household health survey (n = 116 sampled from a census of 354 households), interviews with 45 mothers of young children with high fever, and focus group discussions all indicated that the local *waganga* were among the least frequently utilized health care resources (see Kamat 2004; 2006).[5] The survey revealed that only 8 percent of the respondents and their family members had ever consulted one of the local *waganga*.[6] Almost all of Tinyango's patients, for instance, came from distant places and did not share his ethnic Zaramo identity. Further, the verbal interactions between the healer and his clients were in Kiswahili and not Kizaramo (the *mganga*'s mother tongue) or the client's mother tongue.[7]

Briefly, out of the 25 clients who were interviewed in-depth, the majority (56 percent) were in the 30–50 age group; 72 percent were female clients, 84 percent were married; 92 percent were Muslim; and only 28 percent were Zaramo, with the remaining 72 percent belonging to as many as 12 different *kabila* (Swahili for "tribe"); 48 percent were consulting Tinyango for the first time; 60 percent were accompanied by a family member; and 76 percent did not have a family member or relative living in Mbande or one of the neighboring villages. Significantly, 80 percent of the clients had traveled between 30 minutes and two hours by a mini-bus to reach Mbande to consult a healer practicing in a place that was "far away" (*mbali*) from their own community, their homes, and their immediate social networks. They came to consult Tinyango on problems that included physical ailments such as numbness of extremities (*ganzi*); hernia; hemorrhoids; chronic joint pains; stomach ailment; infertility; impotency; mental health problems, perceived *shetani* or witchcraft-related ailments such as fainting spells, nightmares, children presenting symptoms of *degedege* (the indigenous illness commonly recognized by the Zaramo people of coastal Tanzania as life threatening and one that is best treated by a *mganga* and not a biomedical practitioner); social relationship-related problems such as marital discord, an abusive husband, an adulterous spouse, a fiancé who reneged on his marriage proposal, or a run-away teenager; and misfortunes such as a failed business venture and theft of property.[8]

At first, this situation seemed puzzling. A scenario in which local people do not consult local healers is, after all, incongruous with the large body of anthropological literature that emphasizes the popularity of traditional healers in Africa.[9] At issue, then, is why the people of Mbande do not fully utilize the "traditional" health resources that are locally available to them. And why are the patients of healers who practice in Mbande mostly from distant places and of different *kabila* or ethnic identity than the healers?[10] To ground these questions in an ethnographic context, in the next section I present a profile of Mzee Tinyango, followed by a cultural analysis of the discourse excerpted from audiotaped healer-client dialogues and follow-up interviews with clients.

THE WOUNDED HEALER

Mzee Tinyango is a very articulate *mganga* in his mid-80s.[11] In narrating his life history and the origins of his healing career, he described how he had developed a large boil (*majipu*) on his stomach within the first few months of his first marriage. After he lanced the *majipu* with a penknife, the abscess worsened, and he "died" from the festering wound. As his kin were preparing his body for a burial, he "woke up," and was resurrected. In his quest to find a cure for his ailment, he roamed the forest, discovered some useful medicinal plants, and eventually took it upon himself that he was predestined to become a *mganga*. Thus, the patient was transformed into a healer; the charismatic experience of "waking from the dead" underscored his calling (cf., Good 1987; Janzen 1992; Reis 2000; Swantz 1990; Turner 1967; 1968). The "call," or initial crisis, brought him the revelation of his condition (Levi-Strauss 1963: 180). Tinyango became what Eliade has called the "wounded healer" (Eliade 1959, cited in Reis 2000: 62).[12]

As a *mganga*, Tinyango divines (*kupiga ramli*) inside a *kilinge* (pl. *vilinge*) or consulting room.[13] During a typical *ramli* session, he asks the client (*mteja*)[14] to repeat a few words of prayer in the "call and response" format. In addition, he asks the client to light a wick lamp and, with one puff, to blow out the flame. This deeply meaningful ritual act symbolizes the neutralization of the patient's misfortune or predicament (*shida*, *matatizo*). If the coastal spirit *Kinyamkera* is implicated in the misfortune, then the act of lighting the wick lamp and putting out the flame is, furthermore, repeated seven times, the number seven being the ritual number for the Zaramo (see Swantz 1990). The client and all those inside the *kilinge* then repeat a prayer after the *mganga*. They are also encouraged to say their private prayers.[15]

Too Close to Heal

In light of the anthropological literature on the popularity of healers in East and Central Africa, I initially expected that Tinyango would be popular with the local Zaramo people. After all, one of the local *daladala* mini-bus stops is named after him. However, this was not the case. Other than the relatives to whom he provided free services, the local Zaramo residents rarely came to consult him. Indeed, some key informants would laugh at the very mention of his name. Youth who were amused by my close association with Tinyango and his clients would often laughingly welcome me as: "Oh, here comes Junior Tinyango." The nurses at the local municipal dispensary would also teasingly ask: "Where are you off to next? Mbande's National Hospital? The *real* doctor?" Several people in the village, especially the youth, made fun of Tinyango, particularly with regard to his cuckolded position.[16] While villagers acknowledged that he was certainly a famous *mganga wa kienyiji* (Mzee *kubwa*, *mtalam*, an expert healer), they were quick to add that he was famous among the people who came to see him from afar, not among those who were living in his vicinity.

Most people in Mbande did not go to Tinyango or any of the lesser-known *waganga* practicing in the village because they had either found out on their own or had heard from others that the healers' therapy and medicines (*uganga*) were largely ineffective. They were also not very forthcoming about the *mganga* or *waganga* they went to if and when a need arose. The one exception they made was with regard to cases in which young children were involved. Parents who did consult a *mganga* to deal with an episode of *degedege* did not hesitate to narrate their experiences with a *mganga* even in a public setting (see, for details, Kamat 2008; 2006; see also Hausmann Muela et al. 1998; 2002; Hausmann Muela and Ribera 2003; Makemba et al. 1996; Tarimo et al. 2000; Winch et al. 1996). Mothers who participated in focus group discussions were unanimous in stating that they underestimated (*kudharau*) the *waganga* practicing in the village. As one mother who made a specific mention of Tinyango put it:

> Why should we go to him? People say his medicines don't work. We know that he is doing this mainly as a business (*biashara*); to make a living for himself (*anafuata maisha*). Perhaps we underestimate him (*tunadharau*), but the truth is that we don't go to any of the local *waganga* because they are too close to heal.

Only two participants specifically stated that in consulting a *mganga*, there is a need to remain discreet (*kuweka mambo ya siri*) and therefore they would seek out a *mganga* who practices in a distant place. Here, distance applies geographically, socially, and culturally—a place removed from those immediate social networks, a place full of strangers and lacking the

interwoven community networks of the home.[17] For the people of Mbande, then, the answer to my question, "Why don't you consult your local healers?" was more than obvious; it was a non-issue. While Luedke and West (2005: 6) have noted in their study of borders and healers, "the notion of boundaries is clearly spatial in nature, even when extended to discussions of figurative or social boundaries," for the people of Mbande, the cultural idioms of distance emphasize the geographical and social aspects of distance.[18]

As already mentioned, it is more than just the perceived inefficacy of the medicines or therapy that discourages people from going to a local *mganga*. The social relations of therapy management deeply influence the strategies that people use when seeking a healer. As Pfeiffer (2002: 188) noted in the Mozambican context, "consultations with traditional healers are normally very private and often secretive, because the process itself can potentially endanger help-seekers, who enter an occult world of accusation, confession, and retribution." For the most part, if one is seen going to a local *mganga*, neighbors and relatives might suspect that one has done something that calls for a healer's intervention. Seeking help from a local *mganga* thus carries a moral stain. It suggests that one has potential enemies who might have good cause to launch a malicious spiritual attack such as revenge for a prior wrong (see Brodwin 1992: 64). As Rekdal (1999:468) noted:

> Because the neighbor is one's most significant potential supporter, she or he is also one's worst potential enemy.... The client never knows when the healer may use the client's weaknesses against him, and the best way to ensure that this does not happen is to seek out a healer who is entirely external to one's own social networks.

Further, just as medicines that are received free-of-charge are often perceived as being inferior or worthless and hence ineffective (cf., Nichter 1983; Swantz 1990; van der Geest 1992), in many cultural contexts, for some type of misfortune, therapy that does not entail travel or some sort of a "pilgrimage" may often be perceived as potentially inefficacious (Turner 1974). In Mbande, as in many cultures, geographically, socially, and culturally distant healers are believed to be more powerful and at the same time more neutral than those in one's neighborhood.[19] The next section of this article explores further why those who come to consult healers in Mbande are mainly outsiders (*wageni*), people who have traveled from distant places.

A QUESTION OF FAITH

In the Tanzanian context, some researchers have argued that the introduction of user fees at public health facilities is persuading many poor people to

consult healers because they offer alternatives to cash payments, such as compensation in kind or in work, or payment on a credit basis (Msamanga et al. 1996). However, others have challenged this argument, stating that more often than not, consulting a healer involves considerable expenses (cf., Hausmann Muela et al. 2000). In light of this debate, I documented the interpersonal and dynamic negotiations that took place between the *waganga* and their clients in determining the fees and method of payment. The data from Mbande show little evidence to substantiate the representation of healers as "relatively cheap and hence popular." To the contrary, key informants spontaneously exclaimed "*Waganga ghali sana*!" (Traditional healers are very expensive!). In Mbande, at least, people who consult a *mganga* often end up spending more money than if they were to consult a biomedical practitioner or seek treatment at a biomedical health facility for a similar illness.[20]

On one occasion, Mwanahawa, a 36-year-old Ndengereko woman from downtown Dar es Salaam, came to consult Tinyango regarding her marriage-related misfortune. At the end of the consultation, she paid him Tsh. 10,000 (about $12) as a fee (*ada*)—an extravagant amount. Delighted with his client's generosity, the *mganga* repeatedly assured her: "Don't worry everything is going to be all right. Your problems will disappear just like the flame you put off with a single puff (*kama umezimika taa*)."[21] During several *ramli* sessions, Tinyango was ambiguous about the consultation fees he expected from his clients. Whenever a client broached the topic of fees, he would initiate a convoluted discourse—a verbal performance to highlight his moral identity and his moral position toward his clients—and flourish it with examples of how some of his clients had paid him in the recent past. In doing so, he provided his clients with broad hints as to what he would consider a reasonable payment. Eventually, he would accept whatever the client gave him. Significantly, the amount he received would determine whether he recommended follow-up treatment. To wit, the following verbal exchange highlights the delicate manner in which Tinyango negotiates fees with his clients and the awkwardness that surrounds the fee transactions.

> *Client*: I am grateful to you my grandfather. How many Shillings do I have to pay you?
>
> *Mganga*: I cannot tell you how much to pay. It all depends on you. I will accept whatever you give me in the name of God, and pray for you. I know that other healers, who are already wealthy, negotiate (*wanazungumza*) 50,000, 60,000 Shillings from their clients. As for me, I don't do that; I cannot do that. I accept whatever my clients give me. I am poor, I have no money, I have no land, I have no trees. I am just a temporary guest in this world,

I am alone, I am nearing death, I don't desire a lot, I need only to take care of myself. . . . You don't have to pay me all at once, you can give it to me slowly, and I will do the needful for you, I will pray for you, I will ask God for his blessings, for good luck. Whatever you give me, I will accept it, and thank you for it. I will thank God for it. But whatever it is, I will continue to do my duties for you. I will continue to pray for you.

Client: Ah my grandfather, you have taught me a good lesson (*umenipa mtihani*). Really grandfather, I really want you to do something about my predicament until it has been fully resolved.

Mganga: I will do my job and pray to God that he may bless you.

Client: Really grandfather, you have taught me some good lessons today (she hands Tinyango a 10,000 TShillings bill).

Mganga: Thank you my mother. In the name of Allah, I accept it. It's more than enough. We will pray to God and ask for his blessings. . . .

In the opening statement the client alludes to a fictive kinship term to indicate her desire to establish a personal relationship with the healer in the therapeutic context. Although this would be considered culturally inappropriate in the social context of illness and therapy to pay fees to one's relative for the services rendered, in this instance the client is pragmatic enough to bring the subject of fees into the conversation while deferring the specific amount to the *mganga*. The *mganga*'s response to his client's initial question about fees, however, was not spontaneous, for the elaborate discourse that Tinyango offers is a well-rehearsed speech that I had heard him utter verbatim to many of his clients. His talk about fees was more a moral commentary on the *waganga* in general and the trend toward the "commercialization" of their medicine. The obvious message in Tinyango's discourse is that he is an ethically upright and morally trustworthy person, differing greatly from many other *waganga* who "exploit" their clients by providing them with services at exorbitant prices, "demanded" in payments of thousands of TShillings in contrast to Tinyango's deferring of monetary decisions to his clients. His claim regarding poverty, loneliness, and his lack of desire for worldly goods should be considered more for its rhetorical impact than for its "truth" value. Anyone who consulted with him and observed his surroundings would immediately realize that Tinyango was wealthy compared with most people in the village, constantly surrounded by any one of his four wives, 10 children, or the many grandchildren and great-grandchildren who lived with him in the same compound. Tinyango's suggestion that his client could pay him in installments rather than all at once was a negotiation strategy to insure that his client would continue to patronize him beyond the initial consultation. Even so, Tinyango's "ritual" negotiation surrounding fees may also be considered part of the therapy itself, insofar as the payment contributes to the perceived efficacy of the

treatment. A key point here is that as with most healers in Africa, Tinayango does not offer his services free of cost. As van der Geest (1997: 905) noted:

> Contrary to some popular beliefs, is that traditional healers are *rewarded* for their service. Their personal involvement does not imply that their work remains unrewarded. The social context of the therapeutic act requires reciprocity.... Paying for received treatment is a sign of respect and appreciation. No payment implies no obligation, no appreciation, no relationship.

As such, we are reminded of the significance of establishing a collaborative client-healer relationship, notably shaped through the reciprocal act of payment for the overall therapeutic experience. Indeed, it is important to consider the client's perspective on the dynamics of payment for therapy to healers.

In the following section, two case examples are discussed in detail to illustrate how people who come to consult *waganga* narrate their misfortunes and make sense of their illness and suffering. Highlighted are the complexities that surround their decision to negotiate among healers who live in far away places. Although consulting a healer in a distant place is usually an expensive undertaking, specific social relationship-related conditions often justify long journeys as opposed to conditions that are manifest physically, conditions that are often treated both by a *mganga* and a biomedical practitioner. While a person may bring his or her condition to the attention of a biomedical practitioner and get treatment, in order for him or her to address the "why me?" or "why now?" question, traveling long distances to consult a *mganga* is often justified.

CASE I, POISON (*SUMU*)

Fatuma, a 46-year-old Ngindo woman originally from Kilwa, lives with her husband and five children in Mtoni, a small town about 20 miles from Mbande. Her husband, who is in his mid-50s, works as a truck driver in Dar es Salaam. Fatuma has had seven children, five of whom are alive. Three years ago, her oldest son died in a bus accident. Two weeks later, her 20-year-old daughter died of typhoid. For Fatuma, the sudden death of two of her grown children was too much to bear. Since then, she has gone in and out of depression. When I first met Fatuma at Tinyango's residence, she looked frail and disoriented and had an expressionless face. For most of the day she sat staring blankly at something for minutes on end. Two days later, while sipping a cup of herbal tea that the *mganga* had offered her, she

complained about persistent headaches, intermittent fever, giddiness, and occasional palpitations. Her mood barely changed during the next few days. The following week, I sat in on a *ramli* session inside the *kilinge*, followed by an interview with Fatuma. Fatuma explained that she found it difficult to pin down her problem especially because Tinyango had neither labeled her illness nor had he hinted at the possibility that the underlying etiology of her illness might be witchcraft or sorcery (*uchawi* or *kurogwa*).[22]

Importantly, Fatuma had exhausted several other health resources before coming to Tinyango. She had sought treatment at the Temeke District Hospital, at the Saudi Arabia Hospital, and at many other hospitals and private doctors, all to no avail. She complained that these resources offered her only temporary relief from her persistent headaches and intermittent fever. Her illness was further complicated by the fact that she was experiencing nightmares and delusions. On one occasion, for example, she was sitting all by herself in her room, having locked the door from the inside. Suddenly she became aware that someone was standing in front of her and staring at her without saying a word.

> I was shocked to see a man standing in front of me and staring at me without saying anything. I could not recognize who he was. I tried to gather myself, but then, he had disappeared. Immediately following that I had a severe headache and I collapsed on the ground. When I woke up, I did not have the energy to get up and open the door. I could not even shout for help. Everyone in the house was out on work that day. When they returned home, they saw me lying on the floor in a serious condition. They suspected that I either had malaria or typhoid and so they rushed me to a nearby doctor. The doctor examined me and found that there was nothing wrong with me (*hana tatizo lolote*) except that my blood pressure was low (*moyo imeshuka chini sana*). He said that he did not have any particular medicine for me but advised me to go to a nearby church and pray. When I returned home, my condition became worse. It was then that my family members decided to bring me to Tinyango. If I go to the hospital, they say there is nothing wrong with me. And when I return home, my condition becomes worse.

Fatuma narrated other events to highlight the complicated nature of her illness. A few weeks earlier, while she was in a feverish state, she bolted out of the house and started running on the main road "like a mad woman," as she put it, until late into the night. She was arrested by the police and held at the local police station until she had calmed down enough to be escorted home. In a later interview, Fatuma explained why she had decided to come to Tinyango rather than going to a hospital or some other *mganga* who was in her neighborhood.

> I came here because I know Tinyango will not get tired of treating me. I feel better when I am away from home. To tell you the truth, I feel much better now not just because of Tinyango's medicines, but also because I am away from home and my neighborhood. If I take Tinyango's medicines at home, I don't notice any real improvement in my condition. But if I stay here and take the medicines right here, I feel good.

Tinyango had not labeled Fatuma's illness for nearly a week, which was uncharacteristic given his usual pronouncement of diagnosis during the first *ramli* session.[23] Moreover, he was ambiguous about it with her family members who came to visit her. Apparently he lacked a definite diagnosis for Fatuma, who in turn did not ask any of her family members if they knew what the *mganga* had said about her illness. As Last (1992: 394) has noted, ''not-knowing and not-caring-to-know are genuine attitudes of mind''; knowing may in fact be undesirable because of the complex moral and political implications associated with certain types of knowledge. Two weeks later, in a *ramli* session performed on the day Fatuma's husband had come to visit her, Tinyango concluded that her illness had been brought about by jealous neighbors through sorcery. He advised Fatuma to move out of her neighborhood and live elsewhere until ''the poison'' (*sumu*) in her house had lost its power. While Fatuma was more than willing to move into a different neighborhood, her husband strongly opposed the idea. Two weeks after her stay at Tinyango's place, her husband finally gave in and let Fatuma move into a small house in a nearby town with her youngest daughter. A month later, I learned from her daughter that although Fatuma was still under Tinyango's treatment, she was not responding well. Asked to explain what he thought was Fatuma's ''real'' illness (*magonjwa ya kweli*), Tinyango said, after a long pause, ''She has *UKIMWI*'' (HIV/AIDS).[24] Neither I nor anyone in this world is going to be able to help her recover from her illness. All we can do is pray and ask God for his help and blessings (*tutaomba dua tu*).''

This case exemplifies a situation in which a decision to consult a *mganga* who is considered sufficiently geographically and socially distant is made after elaborate deliberations at the household level. Fatuma and her family members had made the decision to consult Tinyango only after they had exhausted utilizing several ''locally'' available resources, especially biomedical care, to no avail. Their decision entailed the involvement of a therapy management group, emphasizing the idea that the therapeutic choices people make reflect the beliefs and preferences not only of the client but of family and friends as well (see Rubel and Hass 1996: 123). This case also underscores the fact that illnesses that are brought to the attention of a *mganga* are often marked by uncertainty and ambiguity surrounding

diagnosis and treatment. Unlike several other cases I followed, in Fatuma's case, after the *ramli* session, Tinyango did not make an explicit statement about the cause of her illness or its specific nature, despite the fact that he had started Fatuma on medicinal therapy. He advised Fatuma to live elsewhere for a while based on his contextual knowledge that she was not getting along well with her husband. The source of his information that Fatuma was "probably" suffering from HIV/AIDS is not clear; he may have gleaned it from his conversations with Fatuma's family members, who may have mentioned that one of Fatuma's previous doctors had indicated the possibility. In the end, visiting a distant healer brought Fatuma some relief but not a cure. Therein lies the fact that, as with biomedical practitioners, healers do not always manage a cure. When they do not provide a cure, meaning remains unformed; it is not until the patient feels better, or if the patient dies, that the people concerned can really formulate a definitive explanation of what *was* wrong with the patient in the first place (see Harrell 1991: 47).

CASE II, JEALOUSY (*WIVU*)

Ramadhani, a Zaramo man in his early 70s, lives with his 42-year-old wife Mariam and their five children in Malogoro, a village about 100 miles from Mbande. A subsistence farmer who grows cassava, rice, and maize, Ramadhani also earns a reasonably good income by building houses for people in Malogoro and neighboring villages. I first met Ramadhani at Tinyango's place, where he looked very frail and was unwilling to talk. This visit had to do with a personal predicament that he believed was the result of witchcraft—a purposeful attack: "You know how we Swahili people are; we don't want to see our neighbors doing well. We'd rather see them desperately poor, walking naked to the village well. . . ." He described his illness as a "Swahili illness" or "Swahili matter" (*mambo ya Swahili*), meaning that it had an underlying spiritual cause, and therefore is best treated by a *mganga* rather than a biomedical practitioner.

Ramadhani's most recent illness began a year ago when he was building a house in a nearby village. While fixing the roof, he had a blackout (*giza giza*), lost his balance, and fell to the ground. Fortunately he was not seriously hurt, but on his way back home Ramadhani experienced another series of blackouts and collapsed three times. A week later, when Ramadhani returned to his construction site, he had another dizzy spell and fainted once more. At this point, Ramadhani suspected that his fainting spells had to do with his hernia (*ngiri*), although over-the-counter medicines from one of the local pharmacies proved ineffective. He had severe

constipation and could not pass urine for two days. His next step was to go to a *mganga* in a village near Malogoro to find the cause of his illness and to seek appropriate treatment. Upon performing a *ramli*, the *mganga* concluded that his illness was the result of witchcraft initiated by jealous relatives and neighbors. His illness symptoms and misfortune were characteristically interpreted in terms of problems in human relationships (Janzen 1992; Whyte 1997). As Maynard (2004: 135–140) noted, "illness may be embodied in individual 'patients,' but its sources lie elsewhere in the cosmological and moral character of the world.... Healing, however, is not solely the responsibility of the patient. It is also a social act. Patients may be merely symptomatic of a more basic social malaise." In the end, Ramadhani stayed with the *mganga* for two weeks and followed his treatment regime, to no avail.

For Ramadhani, the origins of his misfortune were rooted in his involvement in a land dispute. Several years ago, he had inherited a plot of agricultural land from his grandfather. Because he was already cultivating a large piece of land at the time and did not have the resources to manage additional property, he decided to loan it to one of his relatives. All went well until a year ago when Ramadhani opted to sell the inherited plot of land to the local government, who compensated him for the cashew nut and coconut trees that were planted on the plot. Ramadhani's relatives were displeased with his decision and were frustrated that their work on the land—planting cashew, mango, and coconut trees—was inappropriately recognized, and were jealous of the cash compensation Ramadhani had received. They referred the matter to the court, which ruled in Ramadhani's favor. Envious and angry, one of Ramadhani's relatives decided to kill Ramadhani by witchcraft and take over the land after his death. The local *mganga* that Ramadhani consulted presented such an etiology by linking his dizzy spells to *uchawi* initiated by jealous relatives. By communicating to Ramadhani that his predicament had to do with witchcraft, an "external" factor that was outside of his own being and sense of personhood, the *mganga* was able to reassure Ramadhani that his own basic goodness and self-worth remained intact. Further, through the pronouncement of his diagnosis as *uchawi*, the *mganga* impressed upon Ramadhani that he was not alone in his suffering but rather that his struggle was situated in a larger arena of spiritual forces and evil doers (see Csordas 2002: 55). The *mganga* had identified the cause of Ramadhani's misfortune as having a social basis. However, he expressed his inability to help him resolve the problem "because the enemies are too close and neutralizing the power of medicines." The *mganga* had arrived at this conclusion after he had unsuccessfully treated Ramadhani for nearly a month. He advised Ramadhani to go to any other *mganga* who was far away from Malogoro, which in itself was his "prescription" for Ramadhani's ailment.

Accordingly, Ramadhani traveled to Mbande to consult Tinyango, who confirmed the previous *mganga*'s diagnosis, stating that the poison (*sumu*) planted by jealous relatives was still present and had spread all over his body (*ilikuwa haijatoka mwilini*). Tinyango prescribed a treatment regime that required Ramadhani to stay away from Malogoro for an extended period of time. He also gave him medications to expunge harmful substances from his body and to revitalize his blood, and protective medicines that he could place around his house in Malogoro to neutralize the witchcraft. Ramadhani was convinced that his problem was exacerbated by some women in his village who had joined hands with his jealous relatives and had conspired against him. "They are helping my enemies to make sure that I die. You know how it is in the coastal region. . . . There is an epidemic of witchcraft," he exhorted. As Whyte (1997: 32) noted, determining the cause of a misfortune always involves a consideration of the possible motivation of the agent; this in turn involves moral reflections not only of the agent but of the victim as well as the people responsible for the victim.

In a subsequent interview, Ramadhani credited Tinyango's medicines with helping him to feel better. He was able to move his bowels and also pass urine. At this point of his stay in Mbande, Ramadhani said that if Tinyango's medicines did not help him to fully recover from his illness, his next step would be to go to the Muhimbili National Hospital where he would seek biomedical intervention. However, he was willing to be patient with the *mganga*'s incremental and perhaps inconclusive treatment.

> A *mganga*'s treatment is not like salt that dissolves in water just like that . . .; a *mganga*'s medicine acts gradually; he deals with one symptom at a time. First he will treat your stomach problem, then your headache, and so on.

Two days after I had conducted a second interview with Ramadhani, he was returning from the toilet when he collapsed in Tinyango's courtyard and died on the spot. I learned from his relatives who came to mourn his death that they had in fact decided to take Ramadhani to the Muhimbili National Hospital the very morning of his death.

Given the contextual information that Ramadhani provided, this case suggests that people are willing to travel significant geographic distances in their search for therapy, but only when other attempts to deal with an illness "locally" have been exhausted. Further, it demonstrates that not only local healers but distant healers as well may not be able to provide effective healing. This case also exemplifies people's willingness to pursue alternative therapies. Ramadhani was open to taking recourse to biomedicine (hospital medicine) if the traditional medicine failed. However, doing so would have called for a reinterpretation of his illness and misfortune. This aspect of

health-seeking behavior underscores one of the fundamental axioms of medical anthropology: that patients, their families, and their therapy management groups routinely negotiate among distinct medical traditions. They may even self-consciously reflect on the competing claims to truth and efficacy advanced by particular healers, and they usually perceive little conflict among treatments that may strike others as logically incompatible (see Amarasingham 1980; Brodwin 1992: 58; Janzen 1978). In fact, the lack of conflict that people see among various available modes of therapy is evident. As Harrell (1991: 46) observed, particular illness episodes may call for only one mode of therapy. Alternatively, other illness contexts may result in the patient resorting to more than one therapeutic channel for two reasons: first, since the cause of the illness has yet to be identified, the patient may not know which manner of therapy is proper for treatment; and second, the patient may be concurrently dealing in multiple medical idioms, and thus see no contention among health-seeking strategies that appear to outsiders as rather contradictory.

DISCUSSION

Despite their purportedly holistic approach, the so-called traditional healers and ritual experts in coastal Tanzania may not be as popular among local people and as frequently consulted as they are often made out to be by some academics and health policymakers. Indeed, their popularity may be decreasing in recent years, an indication of both the greater presence of biomedicine in peoples' lives (cf., de Savigny et al. 2004; Tripp 1997) and the fact that medical care in Tanzania, "socialized" until recently, has become increasingly privatized, commercialized, and individualized (Harrington 1999).[25] Following Whyte (1997:208), I argue that the increasing pharmaceuticalization and commodification of health in post-socialist Tanzania has enabled a growing number of people to engage in "the medicinal mode of dealing with misfortunes." Through this process, families and individuals have greater access to pharmaceuticals that are often sold over the counter at private pharmacies. This, in turn, grants them greater liberty to deal with symptoms experimentally rather than having to depend on institutions that have failed them or rituals that link suffering to relations and identities.[26] It is not unusual, then, that those who seek out distant healers to address an inexplicable illness or the sudden onset of misfortune typically do so after they have unsuccessfully tried locally available health care resources. The declining utilization of healers, especially spiritual healers, is indicative of their poor ability to meet the expectations of people in a rapidly changing epidemiological, sociocultural and political environment (McMillen 2004).

In considering the contextual data, the patterns of therapy seeking documented in this article challenge the conventional understandings that "traditional healers are popular because their treatment is concordant with their patients' worldviews" (Nichter and Nordstrom 1989: 369); that healers tend to be popular mostly with members of their own community because of the "cognitive and discursive congruence" facilitated by the sharing of a common social and cultural environment (Rekdal 1999: 467; see also Kilonzo and Simmons 1998); and that most of the people who consult healers are from their own communities. Upon closer examination, one finds that the opposite is often true. In Mbande, most of the people who came to consult Mzee Tinyango were from distant places and did not belong to the *mganga*'s *kabila* or ethnic community. The reasoning behind the apparent allure of the geographically and culturally distant varies. Usually an expensive undertaking, this mode of therapy with a distant healer is pursued by those trusting that the therapy offered by a distant healer would be more efficacious than what was locally available to them. At the same time, in some cases, consulting a healer in a distant place may ultimately turn out to be a more pragmatic and less expensive alternative to what is locally available. A local healer may recommend an elaborate, expensive ritual such as the *madagoli* or *ngoma ya sheitani* ceremony involving relatives and community participation (see Swantz 1995; Janzen 1992). A distant healer, by contrast, is not familiar with the client's social network or community and is consequently less likely to recommend an elaborate therapy involving the extensive participation of family and community members.

The majority of Tinyango's clients who were from distant places had already explored several other resources, each to no avail, without experiencing any obvious ideological conflict. Moreover, nearly all of the interviewed clients clearly stated that they were not only open to the idea of seeking out a different healer elsewhere, but that they were also willing to seek biomedical treatment if the *mganga*'s therapy failed. As Whyte (1982: 2058–2059) reminds us, people frequently consult more than one diviner in order to have more opinions and thereby more options in interpreting a misfortune. Even when a diviner diagnoses only one cause of an affliction, consulting other diviners may expand the possibilities. In the present case, most of Tinyango's clients communicated their "ideological openness" to combining biomedicine with consultation with a *mganga*, in a tone that was pragmatic and matter of fact.[27]

Notwithstanding the paradox that this case study has highlighted about consultations with healers in the Tanzanian context, this article complements Rekdal's (1999) work among the Iraqw of Tanzania and Whyte's (1997) among the Nyole in Uganda insofar as it sheds light on the phenomenon of the search for healing in the geographically, socially, and culturally

distant. However, this study could not confirm that (a) many people in Mbande are consulting *waganga* because "their payment methods are more flexible than that of the formal health care system" (Hausmann Muela et al. 2000), or (b), as Sanders (2001) argued, that witchcraft accusations are on the increase as a result of the tensions generated by structural adjustment programs and that this in turn is *leading* people to consult healers in distant places to counter the effects of being victims of witchcraft (cf. Sanders 2001: 162; see also Ciekawy and Geschiere 1998; Kohnert 1996; Pfeiffer 2002: 191–192).[28]

In coastal Tanzania, then, local people do not necessarily consult local healers for misfortunes that are health related, and those who do turn to seeking out healers in distant places do so in an incremental manner after other resources fail to produce the desired results. Even if an inexplicable and especially severe illness were to persist or a misfortune[29] were to occur, people normally do not adopt a course of action that involves traveling to a distant healer unless they have already exhausted many of the locally available biomedical and/or non-biomedical therapeutic resources. The decision to seek out a *distant* healer is shaped by real-world constraints—additional expenses, inconveniences of travel, separation of family members, and a loss of income.[30] This information is crucial when reconsidering theories about medical decision making in East and Central Africa. If people would much prefer to consult a healer who is geographically and socially distant and with whom they do not have a lot in common as far as ethnic identity is concerned, then this pattern begs the question that Rekdal (1999: 467) has so pertinently raised: "What kind of holism is possible when patient and healer do not share the same language, cultural foundation, or social network?" Ultimately, this pattern also raises the question of whether it is (a) the allure of the distant and the neutrality and confidentiality that a distant healer is able to provide, or that it is (b) the purported "holism" that a healer is able to offer to a client who belongs to his own community because of cultural and cognitive congruence and his knowledge of the client's social network that has the primary impact on patterns of therapeutic resort. This paradox, in particular, underscores the intricacy and complexity of the multifaceted decision-making process in the African context.

On a more applied note, the present case study raises doubts about the rationale for expanding current efforts to integrate "traditional healers" into national health programs (HIV/AIDS in particular),[31] especially on the assumption that they are the best conduit to "local beliefs and practices," and that they are highly regarded in their communities. As such, healers trained under an "integration" program may end up serving clients who come to consult them from distant places rather than members of their own community.[32] In this regard Maynard's (2004: 279) proposal is significant

that given the official interest in popular medicine, and the oft-asserted ideal of integrating healers into a national health-care system, it would be important to find out what "integration" really means and what its consequences are on the ground. This proposal is especially important given the recent revival of interest in the professionalization of traditional healers, in their training and in the scaling up of their role in providing care to HIV/AIDS, AIDS, tuberculosis, and malaria patients in Africa (cf., Green 1999; Homsy et al. 2004; Kayombo et al. 2007; McMillen 2004; Mills et al. 2006). As van der Geest (1997: 910) reminds us:

> Pleas for the integration of traditional and modern medicine seem to be mostly inspired by romantic and simplistic ideas concerning traditional medicine or by economy motives. Medical anthropologists should assess the rationality and feasibility of such recommendations by studying the views of people in the community.

In examining "the views of the people in the community" this case study has provided a nuanced understanding of the complexities involved in making certain generalizations about the so-called traditional healers in Tanzania, especially with regard to their popularity among local people. This article has attempted to provide a more grounded representation of the popularity of healers, especially in their own communities. Although the scenario observed in Mbande reveals only a partial picture, further comparative ethnographic research will help to ascertain the extent to which patterns of therapy seeking observed in Mbande are also found elsewhere in Tanzania. Additional comparative research will shed light on the particulars of why people travel long distances to consult healers beyond the often mentioned need for "neutrality" and "confidentiality." Research into these issues will provide insights into ways in which Tanzania's present health infrastructure could be strengthened so that people have access to better quality of health care "locally" rather than having to seek health care in a far away place.

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NOTES

1. I agree with van der Geest (1997: 904) that the appellation "traditional healer" is "misleading, embarrassing and naïve... because it suggests that there is a more or less homogeneous body of medical thought and practice which can be put together under one name." Thus, in this article I use the term healer instead, noting that healers are a heterogeneous group of people who may not have much in common in terms of their religion, sex, level of education, and practice. In Tanzania, for example, there exist four main types of "traditional healers" or "traditional medical practitioners" as they are variously known: (i) herbalists (ii) herbalist-ritualists, (iii) ritualist-herbalists, and (iv) spiritualists (see, for details, Gessler et al. 1995: 146).
2. All names in this article are pseudonyms.
3. As of May 2003, the Temeke Municipal Medical Office of Health had the names and addresses of a total of 232 "traditional healers" (*waganga wajadi*) on file. Of these, only 71 had registered themselves with the Office of Community Based Health Care and obtained an identity card issued to them by one of the associations of traditional healers such as the *Chama Cha Waganga/Wakunga Tiba Asilia* Tanzania (Tanzania Traditional Practitioners Association or TATHEPA) or CHAWATIATA. The majority of the registered healers had self-identified themselves in the municipal registration form as engaged in *mitishamba na nyiningezo*, meaning herbalist-diviners. To that extent, Tinyango is exemplary of some of the broader patterns in the region. However, he differs from the majority of these healers because he is a highly experienced healer with more than 50 years of practice and he practices in the community where he was born and raised.
4. I documented Mzee Tinyango's interactions with more than 50 of his clients. He received five to seven clients per week. Most of them came to see him during the weekend, and many of them were follow-up clients. There were weeks when he did not receive a single new client, and there were days when he would attend to as many as ten. I audiotaped the dialogue of divination that took place between Tinyango and 25 of his clients (or their parents in cases in which the client was a child) inside the ritual place (*kilinge*), took notes on the non-verbal exchanges, and interviewed them. Most of the clients agreed to let me observe and record the *ramli* session inside the *kilinge*. A few others declined to be interviewed, stating that their particular problem was too personal to be shared with someone whose status and role they did not understand. On at least two occasions, clients politely asked me to leave the *ramli* session, stating that they wanted to discuss matters with the *mganga* that were too private to be voiced in my presence. Of the 25 clients who were interviewed,

I met eight of them only once. Even if they had returned for follow-up treatment, I did not have an opportunity to meet with them again as it was not possible for me to spend all my time at the *kilinge* or monitor the "comings and goings" of all Tinyango's clients. I followed five patients who were long-term patients. They had stayed back at the *mganga*'s place for more than two weeks to complete the therapy. I interviewed only those patients who were very willing. In some cases, the mental and emotional state of the patient was so intense that it was impossible to interview them.

5. I focused my research on Mzee Tinyango as opposed to observing other *waganga* in the area because my initial attempts at documenting interactions between other *waganga* and their *wateja* were futile because they received approximately one patient every two to three months.
6. Ninety-one percent of the sample households had utilized the services of the local municipal dispensary at least once in the past two years. Sixty-five percent of the households had also resorted to at least one of the three private pharmacies in Mbande. These data suggest that the majority of the people in Mbande resort to a biomedical health facility in their search for symptomatic treatment because it is relatively cheaper and simpler than dealing with "causes." Only when biomedical treatment fails and sickness becomes worse will care seekers perhaps deem that dealing with symptoms is not enough and that steps need to be taken to deal with other aspects of the illness experiences that are outside the purview of biomedicine (see Whyte 1997: 26).
7. This is significant in the context of Tanzania's unique history of the national language. While there are at least 126 ethnic groups in Tanzania, each with a distinct language, Kiswahili remains the *lingua franca* of most Tanzanians, mainly due to Julius Nyerere's call for one language, one nation in the spirit of *ujamaa*. Speakers across Tanzania vary significantly in terms of the linguistic and communicative competence in Kiswahili.
8. One of the clients I interviewed was released from jail after having served a nine-month term for alleged theft of government property. She wanted the *mganga* to accord her medicines to "cleanse" her (having lived in a physically and socially polluting place—the jail) before she went to reunite with her two young children. Another of the clients I interviewed and sat in on the *ramli* session initiated the conversation with Tinyango by articulating her problem as wanting to locate a runaway teenage son. During the course of the *ramli*, the client's focus shifted toward a consultation on her brother-in-law's adulterous behavior. Thus, people do not necessarily come to traditional healers such as Tinyango with one single, well-articulated problem, but rather, often present multiple problems which may or may not be health-related.
9. Green (1999: 64), for example, cited Bannerman et al. (1983) to state, "it is generally accepted that about 80 percent of the people of sub-Saharan Africa rely on traditional healers for treatment of all conditions, even if many also visit hospitals." Not known, however, is the frequency with which people in sub-Saharan Africa consult different types of "traditional healers," which would be an important indicator of their "popularity." On the one hand, the purported popularity of healers has often been used to promote programs designed to engage and train them in mainstream health care (see Green 1999; Green et al. 1995; Last and Chavunduka 1986; McMillen 2004; WHO/UNICEF 1978). On the other hand, some researchers and health policymakers have suggested that healers may be directly or indirectly implicated in the many deaths that occur in Africa, especially among children suffering from severe malaria (cf., de Savigny et al. 2004; Makemba et al. 1996; Hausmann Muela and Ribera 2003; Molyneux et al. 2002).
10. The situation in Mbande initially appeared counterintuitive and raised a methodological and practical problem. Given that local people do not consult local healers, I could not document when, where, and which healer they go to if and when the need arose. Owing

to the practical constraints of long distance travel to accompany villagers from Mbande to healers, including time constraints and issues of confidentiality, I could not locate the healers that the people of this village may be consulting. I decided to concentrate my attention on Tinyango and his clients because I could not engage in the "follow the patient" strategy. The question is whether the clients I studied can be treated as proxy for the people of Mbande and their health-seeking behaviors with regard to "traditional" healers. This is an ethnographic question that is beyond the scope of this article.

11. Tinyango has married 14 women. During my fieldwork, he was living with four wives. One of them was in her early 30s. Tinyango had married her when he was in his late 70s or early 80s. His oldest wife had died 20 years ago, and over the years, he has divorced many of his other wives. Tinyango has had 28 children, but only ten are alive today. He has several grandchildren and great-grandchildren.
12. As Reis (2000) noted, "self-transformation is a core feature of the biographies of diviners in Africa. Experiencing a serious illness later divined as being sent by the ancestors is the core of all autobiographies produced by healers in response to the question of how one becomes a healer" (62). Further, a history of involuntary divinership clears healers of selfish motives such as greed for power or money. It is necessary to have suffered a serious illness to be able to claim that one's healing power originates from the ancestors (Reis 2000: 73).
13. In Kiswahili, *kilinge* refers to *ngoma ya shetani*—lit., the dance (also drums) of the spirit(s) (see Janzen 1992). However, *kilingeni*, i.e., "at the *kilinge*," refers to the ritual place where a *mganga* carries out his divination (*ramli*).
14. Tinyango used the term *mteja* (plural *wateja*), literally "client" or "customer," to describe the people who came to consult him. He rarely used the term *mugonjwa*, which in Kiswahili is the more appropriate term for "a patient."
15. In addition to saying some daily prayers, treatment for those possessed by *mahaba ya shetani* (the coastal spirit of love) involves eating cooked rice (*wali*) mixed with medicines (*dawa*) inside the latrine (*choo*). The first time, the medicine is directed toward the coastal spirit (*shetani ya pwani*). The second time, the medicine is directed toward the spirit of the interior (*shetani mlimani*). *Mahaba ya shetani* visits his or her victim seven times each night, and is afraid of the number seven. Eating the seven rice dumplings inside a latrine, a dirty place, is believed to repel the spirit. His other divination technique involves the use of *mwangaza*, which is comprised of bottles containing different medicines (*dawa*), mirrors and talisman of different shapes and sizes, various protective medicines, lion's claws, and horns of other "powerful" animals, all tied together in a bunch and suspended from the roof. After asking his patients a few preliminary questions, Tinyango peers into a small mirror sewn onto his medicine bag (*mfuko*). He shakes the medicine bag a few times, and then rotates his *mwangaza* three times in the clockwise direction. As the *mwangaza* begins to turn back in the anti-clockwise direction, he again peers into the mirror on his medicine bag and matches the images and reflections coming from the mirrors that hang on the *mwangaza*. He repeats this procedure three to four times, and each time he shakes his medicine bag to symbolically align all the medicine bottles inside the medicine bag and those hanging outside the medicine bag in their original order. Then, breaking the silence, he pronounces his diagnosis. In most, but not all cases, the primary diagnosis is *uchawi*, i.e., witchcraft.
16. Two of his wives had eloped with other young men, never to be seen or heard of again. Feeling betrayed, Tinyango scribbled a self-mocking charcoal graffiti in big bold letters at the entrance of the main door: "*Njinga ya kwanza*, *Tinyango*. *Njinga awi moja*, *Tinyango*." ("Tinyango is a big fool; the biggest of them all.")
17. How physically far away this "distant" place is located is for the most part nominal. As such, there are degrees of localness and distance. "Distant" can refer equally to ten

kilometers away or 100, as long as it is not "local" and it is not full of family, friends, acquaintances, and potential enemies.

18. It is important to note that owing to the rapid economic and social transformation that is currently underway in post-liberalization Tanzania, boundaries of the culturally local are being significantly transformed on the urban periphery of cities such as Dar es Salaam.
19. The majority of the 40 or more *waganga* (mostly herbalists) who practice their trade in central Dar es Salaam around the Mnazi Moja park boldly advertise their place of origin as Tanga, which is not only famous for its forests and plants with medicinal properties, but it is also a "far away" place from Dar es Salaam.
20. For some illnesses and misfortunes such as *degedege* or a marital conflict, the *mganga* is considered the primary option, no matter how high the costs are in mitigating the misfortune.
21. In an interview following her *ramli* session, Mwanahawa told me she was worried that her mother-in-law was jeopardizing her marriage. Because she and her husband had decided to live separately, her mother-in-law became spiteful toward Mwanahawa and threatened to persuade her son to divorce her. Mwanahawa wanted her stubborn and abusive mother-in-law to love her, to live peacefully with her, and not to wreck her marriage. She had come to the *mganga* to ask for his help in mitigating her worries.
22. The conceptual distinction between "witchcraft" and "sorcery" is unclear (see Moore and Sanders 2001). The framing of an illness as *uchawi* or otherwise is crucial to the therapeutic impact of the healing; how the *mganga-mteja* encounter may influence the trajectory of the illness. Labeling an illness as a "witchcraft illness" has important implications for the healer as well as the patient/family members and immediate kin and healing network. First, it helps the healer to indicate to the client that the illness/misfortune is beyond the realm of biomedicine, that biomedical treatment would be an inappropriate option to deal with the illness; and second, it helps the healer to communicate to the client that the potential consequences of the illness/misfortune is beyond the client's control.
23. As many medical anthropologists have noted, in contexts of traditional healing, when it comes to therapy, the symptoms of illness are far less important than its root causes. Before treating the symptoms, it is imperative to determine the underlying problem through divination (see Maynard 2004: 140).
24. The Swahili acronym for AIDS, UKIMWI, stands for *ukosefu wa kinga mwilini*, lit., "a lack of protection in the body" (Setel 1999: 251).
25. Pfeiffer (2002) has argued that the declining popularity of "traditional healers" in Mozambique can be attributed to the rise of Pentecostal churches and their weaning away of people from so-called traditional practices. While I acknowledge Pfeiffer's thesis, particularly in discussing Christianized African nations, it is beyond the scope of this article to address the impact Pentecostalism has had on the popularity of *waganga* in coastal Tanzania, as it is a predominantly Islamic region with only a few Pentecostal churches.
26. See also Swantz (1979) for Tanzania and Beckerleg (1994) for Mombassa, Kenya who have argued that, in the East African context, there is an observable decrease in communal aspects of healing and an increasing tendency toward more individualized forms of therapy seeking.
27. In regard to the extent to which pragmatics are dominant in medical choice on the Swahili coast, see Swartz (1997), who asserts that for the most part, people are primarily interested in results rather than theories.
28. When queried whether witchcraft accusations (*uchawi*) have increased during these difficult times, most of my informants dismissed the idea. As one of them put it curtly: "How am I

supposed to know! *Uchawi* is like the air (wind-*upepo*) in your bag. When you open your bag, can you see the air inside? Only a *mganga* can find out and tell you whether or not you are a victim of *uchawi*.''

29. See Whyte (1997: 16–18) for different categories of misfortunes that bring people to diviners: (1) failure of health, by far the most frequent misfortune about which people go to divine, (2) failure of prosperity (e.g., poor crop yields), (3) failures of gender (problems of marriage, reproduction, and sexuality), and (4) failures of personal safety (e.g., lightning that strikes a person).
30. This is not to discount the fact that the perceived etiology of an illness or misfortune also plays a key role in people's choice of therapy. Indeed, local cultural models of therapy seeking indicate the repertoire of illnesses or misfortunes that can only be divined, interpreted, and treated by a ''traditional healer.''
31. Notwithstanding the largely unsuccessful attempts in the 1970s and the 1980s, recently there has been a revival of interest in collaborating with ''traditional healers'' and integrating them into the mainstream health system. Much of this interest has been fostered by the global resurgence of life-threatening infectious diseases such as HIV/AIDS, tuberculosis, and malaria, especially in Africa. This interest is predicated on the assumption that traditional healers are immensely popular and respected by members of their community, and that they are ''people with unique contributions for expanding health services in ways that biomedical physicians cannot, especially with respect to HIV/AIDS'' (McMillen 2004: 900). It may be noted, however, that most of these programs are focused on herbalists and related specialists rather than spiritual healers or diviners.
32. Alternatively, healers who serve local people are themselves not local, but those who have themselves come from distant places.

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