The adapting healer: pioneering through shifting epidemiological and sociocultural landscapes

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Abstract

While it is true that healers selectively adopt and/or refashion aspects of biomedicine, the influence is not unidirectional with information flowing exclusively from hospitals into the workplaces of healers. This article examines healers in Tanga, Tanzania to explore the reciprocal relations between practitioners of indigenous medicine and biomedicine. An abbreviated ethnography of one healer in coastal Tanzania is used to illustrate some of the relevant influences and possible adaptations of contemporary healers. His experiences illuminate how multiple factors, especially sociocultural changes, biomedicine, AIDS, and related research(ers) can influence healers’ adaptations. In his case, biomedical health workers from a non-profit HIV organization call upon him not only to act as a liaison between their services and the community, but more importantly, to provide treatment for opportunistic infections and counseling for patients and to participate in biomedical and scientific projects. Reflecting on his experiences as a healer who has negotiated a position that straddles the world of biomedicine and the world of healers facilitates examination of important issues affecting healers today, including their relationship to biomedical health workers, bioprospectors, governments, non-profit organizations, and professional organizations of healers. Although the healer featured in this article is a pioneer in his own town, there are other examples in Africa where healers and biomedical practitioners are interacting. Therefore, he may represent a trend in healer adaptation.

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Introduction

Medical Anthropology’s perspective on traditional healers has evolved appreciably since early ethnographic accounts that exoticized, and otherwise misunderstood, what we have come to understand to be an integral, and in many ways mundane, element of indigenous medical culture. Today, the literature on healers represents diverse conceptual paradigms, including the changing roles of healers, especially as a consequence of globalization and the transposition of biomedical technology. This paper uses an in-depth case study of healers in Tanga, Tanzania to explore the reciprocal relations between practitioners of indigenous medicine and biomedicine, where knowledge not only flows from hospital to healer, but also from healers to clinical settings.

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Evolving perspectives of healers’ roles

The existing literature on Africa, has problematized healers in the following ways: religious and political leaders (Chavunduka, 1986, p. 29; Feieman, 1985, p. 113; Ityavyar, 1992, pp. 37–38); practitioners of witchcraft (Abrahams, 1994); agents of social cohesion (Ityavyar, 1992, pp. 37–38); psychologists (Jahoda 1961; Rappaport & Dent, 1979); preservers of indigenous and endangered knowledge (Anyinam, 1995, pp. 323–324); and contributors to environmental degradation (Anyinam, 1995, p. 324).

1 Acknowledging the enormous amount of diversity of healers not only among African countries and cultures but within them as well, this discussion will be limited to healers in Africa and focus on one healer in coastal Tanzania.
While some of the works in the larger corpus of literature on healers may overlap discussions on the changing nature of healers’ roles, comparatively little attention has been dedicated to healer adaptation in the context of the transformations of cultures, the ubiquity of biomedicine, and changing epidemiological landscapes in Africa. Researchers have addressed adaptations of healers’ roles in broader discussions of the interactions between biomedicine and local medicine in contexts historical (Feierman, 1983), contemporary (Green, 1988, 1999; Last, 1987; Last & Chavunduka, 1986), political–economic (Turshen, 1977, 1984), and medically pluralistic (Good, 1987; Janzen, 1978; Sofowora, 1982); and also in discussions of overlapping or contrasting theories of disease (Green, 1999).

Beginning about 20 years ago, discussions of healer–biomedicine interactions increasingly centered on healers as supplements to biomedical practitioners for addressing the deficits of primary health care (Feierman, 1981, pp. 403–404; Gessler et al., 1995, pp. 154,158; Green, 1997, 1998, p. 1128; Good, 1987, p. 28; Hoff, 1997; Last, 1986, p. 11; Sofowora, 1982, pp. 101, 109). This trend was catalyzed (or at least encouraged) by the World Health Organization’s goal of “health for all the people of the world by the year 2000,” following the 1978 Alma-Ata Declaration (WHO, 1978). By the 1990s (when it became clear that the goal would not be actualized), biomedicine’s interest in healers had clearly shifted from their services to their medicines.

In the midst of this trend of examining (and at times advocating) the incorporation of healers into biomedicine, the contributions of Feierman and Janzen in Africa have enriched our understanding of the complexities of healers. Not content to simply focus on healers’ practices or their medicines, these researchers “zoom in” to particular temporal, geographical, and sociocultural contexts while also providing broader regional trends. Through in-depth ethnographic (Janzen, 1978, 1992) and historical (Feierman, 1985; Feierman & Janzen, 1992) studies of healers situated in specific contexts and power relationships with biomedicine—as well as with patients, their families, and governments—we can more accurately approximate the fluidity of their lived experiences. Also important to an assessment of healers’ evolving roles is Green (1997, 1999) applied research, which offers more recent examples of encounters between healers and biomedical practitioners in Africa, often in the context of addressing HIV/AIDS.

Although he did not focus on Africa, Landy (1974) was one of the first to describe processes that help to shape the dynamic nature of healers. As we widen our aperture to look at healers cross-culturally, his exploration of the role of the healer is a valuable model for examining role adaptation under conditions of culture change, especially with reference to “Western medical systems.”

In “Role adaptation: traditional curers under the impact of Western medicine,” he explored rapidly changing communities and biomedicine as two primary influences on healers, and identified three roles: adaptive, attenuated, and emergent (1974, p. 106). Although Landy’s explanation is instructive, his categories are limiting in view of the broad range of variability exhibited by healers and their adaptations today. His three categories do not reflect many other healers’ experiences (including the healer featured in this article). Perhaps this is why Landy’s work, though insightful, did not become part of the broader conversation of healers and change.

Oppong’s (1989) examination of Nigerian healers’ changing roles under the influence of biomedicine is one of the few that has referenced and attempted to build upon Landy’s three categories. She profiles 10 healers of several specialties and evaluates their success (or lack of success) in assimilating introduced beliefs and technologies (from biomedicine) into their own practices while maintaining or increasing their status in their own communities. She identifies one healer, the bone setter, as adaptive because he has adopted biomedical “paraphernalia” (wheelchairs, bandages, and some medications) while managing to preserve his role with minimal disturbances to his culture or clientele. For Oppong (1989, p. 609), none of the healers is decidedly attenuated or emergent. Thus, no role status has been assigned to nine healers. Virtually nothing else has been published on the topic of healer adaptation in general. In part, this is likely due to the difficulty that Oppong and many others encounter in describing trends among such a diverse group of people called “traditional healers.”

Before proceeding, it is important to point out that although the label “traditional healer” is used frequently, it is problematic for two reasons. (1) It frames contemporary healers with reference to their past, which implies a status that denies or underemphasizes the dynamic nature of healers. (2) It groups together a heterogeneous constellation of people who do not necessarily have much in common culturally, socially, or professionally. There is even a lack of intra-cultural consensus on the identity of healers, their skills, knowledge (Last, 1992, p. 398), specialties, adherence to

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2 Landy defined role adaptation as “the process of attaining an operational sociopsychological steady state by the occupant of a status or status set through sequences of ‘role bargains’ or transactions among alternative role behaviors.”

3 Curer in synonymous with healer for the purposes of this paper.

4 See Last (1986, pp. 1–19); Last (1987, pp. 10–11); Rekdal (1999, p. 472) for a related discussion on the ambiguities in the use of the term “traditional medicine.”
cultural standards, treatments, diagnostics, and nomenclature of plant medicines (Waldram, 2000, p. 615).

Acknowledging the shortcomings of the label “traditional healer,” we will forgo “traditional” and, as a matter of convenience, use “healer” to refer to a local non-biomedical health practitioner who has inherited, trained in, or created methods that utilize botanical, animal, and mineral products, perhaps symbolic methods and ingredients as well, and is sought out to treat physical, mental, and social diseases, and conflicts in his or her community. Although the term “healer” also is problematic because it lumps together too many disparate individuals, it allows the possibility that healers’ roles change. Like medical cultures worldwide, including biomedicine, African “traditional” medicines are “living style[s] of treatment, and capable of adaptation by showcasing one study. I offer an abbreviated ethnography of Mohamed Kassomo, a healer in coastal Tanzania, to illustrate some of the relevant influences and possible adaptations of contemporary healers. Reflecting on his experiences as a healer who has negotiated a position that straddles the world of biomedicine and that of healers facilitates examination of an important issue affecting healers’ changing roles.

This paper contributes to a new understanding of healer adaptation by showcasing one study. I offer an abbreviated ethnography of Mohamed Kassomo, a healer in coastal Tanzania, to illustrate some of the relevant influences and possible adaptations of contemporary healers. Reflecting on his experiences as a healer who has negotiated a position that straddles the world of biomedicine and that of healers facilitates examination of an important issue affecting healers today— including their relationship to biomedical health workers, bioprospectors, governments, non-profit organizations, and professional organizations of healers.

History of healers in Tanzania

To fully understand the evolution of the healer’s role calls for an exhaustive exploration of the cultural, social, political, and intellectual life over hundreds of years in Africa. Here, I necessarily limit discussion to some of the major trends that have been significant to the place of Tanzanian healers in larger society; however, the experiences of healers in Tanzania are not completely unique as Tanzania shares a colonial past that is repeated transglobally.

Before European occupation, each community had a member (or members) who specialized in some sort of healing. Compared to their contemporaries, healers were more community-oriented, and focused on preventive as well as curative methods. For example, in northeast Tanzania between the Usambara Mountains and the Indian Ocean (now Tanga Region), healers (among other political leaders) influenced village planning including environmental and sanitation concerns. They helped regulate the placement and designs of villages, irrigation channels, human waste, and burial sites. Healers also addressed infection control by aiding in expelling social deviants (witches) and polluted individuals (e.g., those infected by smallpox) who were perceived as threats to the community (Feierman, 1985, p. 119).

During the German colonial period, beginning in 1888, healers were arrested, beaten, and killed (Feierman, 1985, p. 119). Because healing had to be secretive, it was difficult to pass information on to new generations and the number of healers diminished (Turshen, 1984, p. 146). Healers were further forced from public roles where they owned political, economic, social, and ecological control into private roles where they treated individuals for specific problems.

By independence (1964), the larger population of Socialist Tanzania had grown divided on the issue of healers. Some citizens saw healing as a symbolic departure from colonization and a return to indigenous/African values and culture. Others, including those aligned with the government, understood healers and their clients as dishonest, backwards, irrational, and even evil. This dichotomy still exists, although there are no definite lines as to who supports or rejects healers as valuable components of contemporary health care systems. Today, proponents and opponents of healers’ practices are found in government ministries, hospitals, and villages.

Healers also were affected by another shift in politics since independence, specifically the transition from

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5 Although “traditional birth attendants (TBAs)” fall into my category of “healers” their situation is quite distinct from other healers with reference to their interactions and encounters with biomedical practitioners and they are outside the scope of this paper. The services of TBAs are often recognized and targeted by development and aid organizations. These organizations train TBAs, provide them with supplies, welcome them and their services into hospitals, and engage them in other relationships that other healers typically do not enjoy.

6 Gessler et al. (1995, p. 150) provide an interesting example with one Tanzanian healer whose grandmother was also a healer. He studied Ayurvedic medicine and homeopathy in India, then returned home to incorporate it into the healing he learned from his grandmother.
Ujamaa Socialism to a market economy in 1986. For example, some elderly healers recalled that when they were young (under socialism) village healers treated patients cooperatively. They remarked that now (under a market economy) healers are more competitive and less willing to share information or refer patients.

Today, botanical medicines have become the hallmark of the relationship between bioscientists and healers. The Institute of Traditional Medicine (ITM) (1998) at Muhimbili University began conducting research with healers on botanical medicines in the 1970s. Its July 1997–June 1998 annual report states the following objectives: “to conduct investigations on plants, animals and mineral products used for medicinal purposes...including the evaluation, rationalization, understanding, and promotion of traditional medicine. Also to identify and discourage harmful products, customs, and practices which are detrimental to the healthy well-being of man.” Exchanging information or collaborating with healers (an activity ITM engaged in previously) is not stated as an objective, which is indicative of the shift from an interest in healers’ services towards healers’ medicines.

**Research setting and background**

**Tanga**

Tanga Region in northeastern Tanzania borders Kenya to the north, the Indian Ocean to the east, and the Morogoro and Coast Regions to the west and south. The predominant religion in the region is Islam. The primary language is Swahili although the first language of some inhabitants of Tanga Region is either Digo or Sambaa, two of the predominant ethnic groups in the area. The population of Tanzania is comprised of about 1% of people of Indian and Arab descent (Electric Library, 2002), who are concentrated in coastal areas, including Tanga, and in Unguja and Pemba (the islands off mainland Tanzania).

The research was conducted over two periods totaling 16 months during which the author was in-residence in Tanga town, a coastal semi-urban population of 202,900 (The World Gazetteer, 2001). Tanga town proper is a commercial and residential mix that takes advantage of the physical infrastructure remaining from the German and British colonial periods (1884–1914 and 1914–1961, respectively). In the area surrounding the town, paved roads, piped water, and electricity are not common. For the most part, Tanga subsistence is characterized by fishing, small-scale livestock (goats, chickens), dairy cattle farming, and/or the production of crops such as coconuts, cassava, and oranges. The sisal and tea plantations that previously employed many locals, the port, professional institutions, and service industries are viable sources of income for relatively few Tanga residents today. This has contributed to Tanga’s declining economy, a notable phenomenon in a country that already ranks among the poorest worldwide.

**Health services**

Tanga town offers a variety of health services, the largest and best known of which is the government regional referral hospital, Bombo Hospital. There are also a number of smaller private or mission hospitals and clinics that are more expensive than the government hospitals, but are usually preferred. Botanical medicines from India are available in a few small, Indian-owned shops; and Tanga town now also has one Chinese botanical medicine shop. In the face of all this competition, healers retain a notable following. The fact that healers in Tanga continue to exist in close proximity to a variety of health-service providers demonstrates their value to the community; yet not all healers are valued equally.

Adapting to the changing expectations and needs of clients may prompt healers to incorporate ideas or artifacts from biomedicine into their own practices and synthesize or create “new” disease models or treatments. Adopting elements of biomedicine and western science increases the ambiguity of the healer’s role but it also facilitates his or her ability to adapt to changing surroundings and client expectations. “The combination of the motivated sufferer on one hand, and the dynamics of medical pluralism on the other, makes affliction a locus for innovation in local communities” (Whyte, 1989, p. 299). How or what a healer integrates from biomedicine as well as how the local biomedical community and the lay community perceive these borrowings may determine whether the healer’s status increases or declines. For example, Tanzanian healers who wear white coats and use pharmaceuticals, stethoscopes (Semali, 1986, p. 94), or biomedical terminology may be perceived as charlatans by biomedical practitioners, especially if healers use these biomedical artifacts in ways that differ from those prescribed by biomedicine; however, the local biomedical community does not criticize Kassomo, the healer discussed in this article. Although he uses medical illustrations and photographs when interacting with clients, draws from botanical research, and sends his clients for HIV testing, local health workers accept him and respect his work that integrates bioscience with his own knowledge and practices.

**AIDS**

In Tanzania, AIDS has surpassed malaria as the leading cause of death in adults, and is likely to do so for children in the near future. In Tanga region, the 1998
statistics for the infection rate for blood donors alone was 7.3% for males and 11.9% for females. Between 1992 and 1998, there were 26,083 cases of AIDS reported in the Tanga Region, but the National AIDS Control Program (NACP) (1999) estimates that only 1 in 5 cases is reported. These figures invariably suggest high infection rates. Clearly, AIDS has been a catalyst for cultural, economic, and physiological stress on communities and therefore, it has been a catalyst for healer adaptation (which will be described later).

Methods

Interviews were pre-tested in villages around Pangani (a coastal town neighboring Tanga Town) with five healers who had participated in Tanga AIDS Working Group (TAWG) seminars. During the first research period, from December 1998 to December 1999, semi-structured and unstructured interviews were conducted in Swahili with 20 Tanga healers in their homes or work places.

All were members of the Tanzania Traditional Health Practitioners Association (in Swahili Chama cha Waganga na Wakunga Astilia Tanzania, hereafter referred to as CHAWATIATA). All of the healers interviewed had participated in seminars given by TAWG on sexually transmitted infections and AIDS. The objectives of the interviews were to: (1) learn about the different types of healers in Tanga who interact with TAWG; (2) obtain feedback from the healers on the format, content, and methods used in the seminar; (3) assess the healers’ understanding of AIDS symptoms, modes of transmission, and methods for protecting both themselves as healers and for the general population; (4) assess healers’ perspectives on collaboration with fellow healers and with biomedical health workers or scientists. Additional healers outside Tanga (in Dar es Salaam, Moshi, and Mwanga) who collaborate with biomedical health workers (other than TAWG) were visited in their clinics and participated in unstructured interviews. Their perspectives and experiences further demonstrated the various ways healers in Tanzania interact with biomedical health workers.

During this same period, the research focused on Kassomo, a healer in Tanga, and Zingiri, one of the plant medicines he uses to treat opportunistic infections of AIDS. Zingiri was selected due to Kassomo’s interest in getting feedback on his plant medicine that had recently gained increased popularity. Research was conducted through semi- and unstructured interviews with Kassomo, his clients, and his assistants. Participant observation techniques were also used in collecting, preparing, and packaging Kassomo’s plant medicines; attending healing sessions with Kassomo, other healers, and their clients; and attending ritual healer celebra-

Findings and discussion

Tanga AIDS Working Group (TAWG)

TAWG evolved from meetings that a German doctor initiated with Tanga healers in 1990. This physician noted that many patients visited healers prior to visiting him and suspected that the healers’ treatments either exacerbated or initiated their problems. (He probably did not see those who improved after visiting healers.) This doctor initiated a referral network with local healers and other hospital workers who became the founders of TAWG (the majority of which were and still are Tanzanians). Their initial meeting evolved into workshops for the healers with subjects such as how to recognize certain diseases, when to refer a patient to the hospital, and how to cooperate with biomedical personnel. Subsequent meetings became less like training sessions and more like dialogues based on exchanging practices and experiences with the goal of cooperating to better serve the local population. For example, they discussed malaria, meningitis, and gastrointestinal problems.

One day as they discussed AIDS, Waziri Mrisho, an 85-year-old healer, explained that his father treated patients with similar symptoms. Mrisho requested and was permitted to treat one of the doctor’s AIDS patients who subsequently (to the surprise of the hospital staff) improved, was discharged from the hospital, and resumed his job as a gas station attendant. This marked the beginning of a different relationship between healers and hospital staff in Tanga. Previously, the healers were not respected or welcomed into the hospital and they did not readily share information with health workers. AIDS changed that (Scheinman, Mberesero, & Mathias, 1998). TAWG continues to hold workshops and meetings with healers, and has since appointed Kassomo as its primary healer. Although the income is small and

7See McMillen and Scheinman (1999); Bodeker et al. (2000) for more recent information on TAWG’s activities.
the work is demanding, Kassomo feels a responsibility as a healer to provide these much needed services to the community. “My work is not like selling coconuts. If a person is sick and needs medicine, it is my responsibility to help them” (personal communication, September 22, 2000).

Healers in Tanga

Most of the 20 healers (9 women and 11 men) who participated in semi-structured interviews are originally from Tanga region, Muslim, between 30 and 50 years of age, and represent a range of specialties and types of therapies. For more than half of these healers, divining and spirit possession are central to establishing diagnosis, prognosis, or composition of appropriate medicines. Although they treat health problems related to disease or injury, many healers in Tanga town focus on treating problems related to uchawi (witchcraft), kichaa (insanity), and mshetani/majini (spirits). These healers often consider themselves to be wa nga wa majini or wa nga wa mashetani. In their healing sessions they use tunguri (small gourds filled with medicines used to divine, and call or harness spirits), although their therapies also may include other botanical and mineral medicines or verses from the Koran.

Healers need to stay in touch with their communities by adapting to their changes while also providing an element of continuity. Indeed, Tanzanian healers who specialize in kismarti (medicine for good luck), dawa ya kita na (medicine for male virility), or dawa ya biasha ra (medicine for a prosperous business) were especially noticeable in urban areas (including Tanga Town, but more so in the busier cities of Arusha and Dar es Salaam) where many residents are new urbanites and may be experiencing extreme social and cultural changes and anxiety as they transition from their village settings. In other words, healers may be acting as culture change brokers who guide and reassure people’s places in reorganized societies. (See also Green, 1988, p. 1128 for examples in Botswana, Swaziland, and Nigeria.)

Most healers said that the majority of their clients are women from their own communities, but some have clients who travel from other regions or countries. Less than half said they have received an AIDS patient and even fewer claimed to treat HIV/AIDS. Healers primarily talked about their abilities to treat and cure patients, but a few talked about disease prevention in the context of discouraging mosquito populations, the importance of cleanliness, and restrictions on sexual activities.

The popularity and economic status of the healers varied. One man who specialized in treatments that derive from the Koran had a car and mobile phone, and frequently was summoned to other countries in Africa and Europe to treat clients. Other healers who did not have any visible materia medica in their treatment rooms said they had only a few clients. The sheer number of healers in Tanga and the resulting competition is likely a contributing factor to the attenuating status of some of these healers. Landy described attenuated healers as those who align with “traditional” ideas (that are no longer widely valued by the community), are hesitant to consider new ones, and sometimes express distrust of biomedical models and practitioners. These qualities correlate with some of the more vulnerable types of healers interviewed in Tanga who have become less popular as they meet fewer expectations of the changing communities (1974, p. 118).

Healer organizations

In 1985, the WHO (1985) reported that there were healer organizations in over 20 African countries, one of which was Tanzania. A number of healer organizations have come and gone since Tanzania’s independence, but each one has focused on similar goals. Green (1988, p. 1126) noted, “A characteristic of the healers that comprise these associations is that they are especially interested in learning more about modern/Western health care, they want to work in cooperation with the modern sector through involvement with ministries of health, they want to change the popular image of traditional healers as ‘primitive witch doctors,’ and they want to become respectable among government officials as they typically are in their own communities.” These same interests are represented in the charter of the Tanga branch of CHAWATIATA (2000). Many of its members also talked about the role of the organization in protecting healers from being treated unfairly by scientists or pharmaceutical companies as a number of them had encounters with national (ITM) and international (Shaman Pharmaceuticals) bioprospectors that left them feeling taken advantage of or otherwise disrespected.

In Tanga Town, CHAWATIATA leaders objected to TAWG’s interaction with healers who are not members. TAWG, in efforts to smooth relations and show their respect for healers, agreed to work through the CHAWATIATA Chairperson to recruit healers to seminars. However, conflicts impede relations between TAWG and Tanga healers as they have created jealousy and suspicion among members as well as between members and non-members. Green (1997, p. 58) notes similar conflicts in other African healer organizations and identifies “jealousy, squabbling and factionalism among healers and between the leadership and rank-and-file membership of professional association of healers, which organizations served as the basis of initial recruitment” as barriers to successful collaboration between healers and biomedical health workers.
Interviews revealed that some healers felt it was unfair of TAWG to only use (and therefore privilege) Kassomo’s medicines. Other healers portrayed him as someone who works too hard, and is paid too little, claiming that although they would like to work with TAWG they would not agree to working under Kassomo’s conditions. Usually, these healers who portrayed Kassomo as someone who has been taken advantage of, were not particularly in demand. Those healers whose services were popular and had many clients admired Kassomo and criticized healers who were too business and profit-oriented as not being “real healers.”

Joining CHAWATIATA opens the door for healers to interact with TAWG, another way to gain status. “Healers may well enjoy prestige in their local communities, but collaboration with physicians or government officials bestows a respectability and recognition in the modern/urban sector that indigenous practitioners have come to value. This prestige, along with any skills acquired in Western medicine as a result of contact with Western-trained practitioners, enables a healer to attract more clients and expand his or her practice” (Green, 1988, p. 1128). Although healers are not taught “skills” per say (e.g., how to give injections) by TAWG, attending its seminars and meetings becomes not only a way to learn about biomedical perspectives of disease, but also an opportunity to enhance status and legitimacy as a healer through a public validation of their skills and knowledge. (See Svarstad (2000) for further discussion.)

Kassomo

A brief ethnography

Kassomo is a healer who lives just outside of Tanga town. He is Muslim, 47-years-old, and married with four children. He identifies with his father’s ethnic group, Fipa, though his mother and her relative that trained him are Digo. Kassomo considers himself to be a mguna wa miti shamba (healer who uses wild plants). In addition to treating disease, Kassomo also counsels and educates clients, community members, and fellow healers, which are services that healers have long provided. He has also been appointed CHAWATIATA’s Research Coordinator because healers recognize that he is constantly experimenting with and researching plants through his own endeavors and through projects with researchers or health workers.

The vast majority of the 20 healers interviewed in this research described one or a combination of the following paths that led them to be a healer in Tanzania: inheritance, initiation by spirits, the experience of having a chronic or long-term illness cured by a healer, or personal decision (Gessler et al. (1995, p. 150) mention these same categories).9 Kassomo’s experience touches on all of these elements. At age six, he first encountered a jini mkubwa (powerful spirit). Frequent sickness episodes and dreams of the spirit marked Kassomo’s childhood and early adolescence, which were the signs that he was meant to become a healer. During these years, hospital medicines provided him no relief. However, he eventually regained health by following his spirit’s directions on which plants to use and how to prepare them to treat himself. Kassomo accepted what he saw as his fate, left secondary school, and began an apprenticeship under his uncle’s son who is also a healer. He apprenticed for 11 years and has been practicing independently since 1971.10 The same jini (and only that jini) that was his impetus to become a healer is also the driving influence in his current practice.

Although Kassomo’s training did include learning about plants and their medicinal uses it focused heavily on the use of tunguri, which are especially used in spirit possession. During this training he also developed his own unique healing practices and inherited abilities, which focused more on the plants themselves. After completing 11 years of apprenticeship in Tanga, Kassomo moved to the capital city of Dar es Salaam to practice. Because his business there did not flourish, he returned to Tanga but his practice still did not provide sufficient funds for supporting his family, so he was forced to work as a day laborer at the port.

At the advice of a local healer, Kassomo began to work independently and ceased using tunguri and doing spirit possession, basing his treatments exclusively on plant medicines. Today, his office contains no tunguri or other artifacts commonly used by healers who do spirit possessions. Instead, his walls display posters promoting “Salama” condoms; a calendar featuring Julius K. Nyerere; and another calendar of African healers in

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8 In Redkal’s 1999 article, he discussed how culturally distant healers are attributed as having more power than local ones for the Iraqw in Tanzania. This was not evident in this research, however. No clients interviewed ever affiliated themselves with the Fipa group, and none ever mentioned Kassomo’s affiliation with the Fipa group—so it is uncertain as to what effect it might have.

9 Janzen’s (1978, p. 196) research in former Zaire revealed the following similar ways of becoming a healer: “visionary encounters with the spirit world during a personal trauma… being an apprentice to a master mguna [healer], purchasing treatments…and experimenting with the cures”. In his study of Botoku, Ghana healers, Tsey (1997, p. 1067) identified three paths to coming a healer: “informal learning from a close family member…formal apprenticeship under an established practitioner...[and] through spiritual “calling”.

10 Reynold’s (1986) discussion of the process by which healers in Mashonaland are initiated into the healing role is instructive here, although Kassomo’s experience differs somewhat.
their workplaces. His shelves contain notebooks and folders with patient information, his own research, copies of research reports he has been involved in, a book on plants, a booklet with photographs depicting manifestations of Herpes Zoster (which will be explained later), sealed plastic bags with individually measured doses of prepared plant medicines, and kerosene lamps. He does not have either the artifacts of a healer who does spirit possession or the artifacts of a biomedical practitioner.

Although Kassomo does not utilize spirits as other Tanga healers do, he does not reject all aspects of spirits. He understands his healing abilities to be a gift from God and acknowledges the influences of spirits in everyday events; however, he does not employ them in therapy sessions or mediate spirit possession. Since changing his practice, Kassomo has not become rich as a healer. However, his practice alone provides sufficient funds to support his family.

Kassomo treats a variety of diseases but he specializes in treating people with skin problems, colds, coughs, and AIDS. His small, two-room, mud and thatch clinic is located a few minutes walk from highly traveled unpaved road which is about the same distance from his home. There is no sign advertising his services, but the community knows him. In fact, local mini bus conductors often call out his name to announce the stop when they reach the point in the road near his clinic.

Kassomo has learned about some plant medicines from other healers; however, he says that most of them have come to him through dreams. An example of how Kassomo’s dreams and his interaction with the biomedical and scientific communities influence his work is illustrated by Zingiri, one of the plants in his pharmacopoeia used to treat opportunistic infections of AIDS. This example also illustrates how he has adapted to the shifting epidemiological and sociocultural landscape as he moves back and forth from the forest to the hospital, from old local knowledge to new imported knowledge, and from empirically proven treatments to ones based on intuition or directives from his spirit. “Mimi niko kati-kati” (I am in the middle) he says, describing his position between the realms of hospitals and healers.

Kassomo has been using Zingiri for over 25 years; however, his mentor did not introduce it to him. As a new apprentice, he was drawn to this unfamiliar plant while walking alone through the grasslands. He brought a sample to his mentor who explained that although he did not use Zingiri, other healers use it to treat colds. Initially, Kassomo used Zingiri to treat colds and women’s problems and he noticed that it was quite effective. Years after he began practicing independently, his jini instructed him (through dreams) to use Zingiri to treat fungus and blisters on the skin and in the mouth. He experimented, was encouraged by the results, and continued to use it to treat people suffering from fungus and blisters.

In 1991, Kassomo was visited by a person who had all the symptoms of AIDS. (This was previous to him becoming TAWG’s primary healer although he had learned about AIDS in a seminar given by TAWG.) He was feverish, weak, wasting, and had skin problems. Even though this patient had been using medicines from the healer who was affiliated with TAWG, his condition had not improved. However, after using Kassomo’s medicines (one of which was Zingiri), his fever disappeared, and he gained strength and 4 kg. Because this patient began treatment with TAWG, he reported back to TAWG after using Kassomo’s medicines. Soon afterward, TAWG health workers came to visit Kassomo and they asked him to join them. This marked the beginning of Kassomo’s working relationship with TAWG. In 1994, he officially became its primary healer, completely replacing the previous one. He has since been responsible for preparing all of the plant medicines supplied to its clients. The core of these are the three medicines that the late Mrisho had introduced to TAWG. He dispenses these three and other plant medicines that TAWG had not used previously to some TAWG clients who visit him in his office, but the majority receive these medicines from a TAWG nurse who either dispenses them from the TAWG office in the hospital or delivers them during “homecare visits.” There is no shortage of healers who want their medicines “adopted” by TAWG, yet TAWG is very selective, using only Kassomo’s medicines because staff members had seen evidence that these medicines helped their patients. Bioprospectors have also played a role in determining that an additional medicine from Kassomo be incorporated into TAWG’s treatment regimen.

Shaman and bioprospecting in Tanga

Bioprospectors have become part of Kassomo’s and many other healers’ experiences. They too, need to be

11 Oppong (1989, p. 608) describes a traditional psychiatrist for whom dreams were also important from an early age. He had “a very unusual method of training. He had learnt through dreams from an early age which herbs to join together and which roots to mix to make medicines. He still had such experiences.” Also see Reynolds (1986).

12 Although he did not specify the type of matatizo ya wangawake (women’s problems), healers and laypeople use this polite term to refer to any problem involving women’s genitalia, and he could have been referring to vaginal candidiasis.

13 Again, he did not specify what type of matatizo ya ngozi (skin problems).

14 This was the son of the late Mrisho, TAWG’s first primary healer.
considered in a discussion of healer experiences and adaptation. In Kassomo’s case, Shaman Pharmaceuticals represents another way that biomedical science has influenced healers. Shaman researchers came to Tanzania in 1993 to look for plants that might provide leads for drug discovery. They collaborated with local healers, one of whom was Kassomo, to identify plants and learn their applications.

As an act of reciprocity for those who participated in Shaman’s research (many were associated with TAWG), Shaman researchers conducted an ethnobotanical workshop to strengthen local research efforts. In fact, Kassomo learned to prepare plant voucher specimens as a result of the workshop. When Shaman’s research team left Tanga, they took plants that were identified by healers and analyzed them in the United States. One of these was Zingiri, which turned out to be a “hit” against a cell line infected with a strain of Herpes Zoster, a common problem that affects People Living With HIV/AIDS (PLWA). In addition, fungicidal activity was found against three opportunistic infections in PLWA: Candida albicans (a fungus that causes oral thrush and vaginal candidiasis), Cryptococcus neoformans (a fungus that can affect skin, respiratory system, skeletal system, CNS, and urinary tract), and Trichophyton rubrum (a fungus that causes tinea or ringworm). In vitro fungicidal activity was also observed against Aspergillus fumigatus (a fungus that can infect the lungs, blood, and other organs).

Shaman Pharmaceuticals did not pursue Zingiri in creating a pharmaceutical, however, it did return the laboratory results to Tanga. One of TAWG’s board members, who had served as a liaison between healers and Shaman researchers, communicated the report about Zingiri to Kassomo who had since become TAWG’s primary healer. Kassomo was not surprised by the laboratory results; he had been using Zingiri for almost 10 years to treat Herpes and other similar problems.

For Kassomo, Shaman had not identified a new medicine, or even justified his use of it. The company had simply given the disease a different name, “Herpes Zoster.” Nevertheless, the feedback from Shaman and the TAWG board member did encourage Kassomo to do research of his own specifically on Herpes Zoster. Shaman also provided TAWG with a booklet of medical photographs illustrating the manifestations of Herpes Zoster and Kassomo began to use this in his diagnosis process, which involves discussing symptoms with his clients. He kept records on more than 100 patients whom he identified as having Herpes Zoster and treated them with Zingiri. Kassomo found that some patients who had not experienced relief from using pharmaceuticals recovered from chronic cases of Herpes Zoster after being treated with Zingiri. (TAWG health workers have seen the same results with other patients and have reported their observations more recently.) He also uses this book to help educate other healers how to recognize herpes.

While Shaman’s “discovery” did not dramatically affect Kassomo’s use of Zingiri, it did have a significant effect on TAWG. It prompted TAWG to include Zingiri among the plant medicines it already dispensed. TAWG has since used Zingiri as an alternative to an expensive and often ineffective pharmaceutical it uses to treat Herpes (among other things). From this point, Zingiri’s popularity has increased. People come to TAWG or to Kassomo’s office just to request Zingiri for Herpes Zoster, thrush, or other skin problems. Some hospital staff members even recommend it to patients for colds and asthma. Clearly, endorsements from biomedicine have enhanced the notoriety of Zingiri and Kassomo.

Clients

In 2000, TAWG clients routinely identified plant medicines as the most valuable service they receive through TAWG. However, only 28% of interviewed clients even knew that a healer provided these to TAWG, and not all of these even knew Kassomo as that healer. 48% of clients interviewed said they would like to meet Kassomo (in addition to the 28% who had already met him). The most popular reasons were to (1) learn more about his medicines—how they work, how to best prepare them, and whether there are any other medicines they should use for their specific condition (2) ask advice about personal problems, and (3) to express their thanks to the person who has helped them feel better. Kassomo says that in the past, a TAWG homecare nurse has taken him to see patients who had persistent problems that were not responding to the botanical medicines they normally give. In these

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15 At the time, Shaman Pharmaceuticals was a development-stage company based in California. It worked to identify and manufacture plant-based pharmaceuticals by isolating the compounds of tropical plants with a history of medical use. It changed its methods and goals and was renamed as Shaman Botanicals, and most recently has been recreated as PS.

16 Shaman also made a financial donation to TAWG.

17 In fact, he taught the author how to make plant voucher specimens. This is another example of the back and forth influences and exchange of information between healers and scientists.

18 These test results are documented in a handwritten note from a Shaman Pharmaceuticals employee in June 1995 to David Scheinman, a TAWG Board Member who visited Shaman Pharmaceuticals headquarters in California. At the time of the research this note was on file in Scheinman’s office in Tanga.

19 Most clients who said they were not interested in meeting him said they were afraid of healers or did not believe in them.
cases, Kassomo provided other botanical medicines based on the client’s condition and his/her treatment plan. However, it is not common now for TAWG to bring Kassomo on homecare visits.

Kassomo said that because TAWG dispenses his medicines, fewer patients come to his office, which enables him to actually treat more patients without having to be available in his office all the time. This allows him the freedom to take trips into the field (sometimes for days) to do utafiti (research) and explore more plant medicines. On separate occasions, he said that he would like to have more contact with the people who use his medicines through TAWG, but that it had not been made possible (i.e., TAWG had not connected him with patients). Not sharing personal information about clients with Kassomo may simply be the result of TAWG respecting clients who prefer to be totally anonymous. On the other hand, client interviews revealed that TAWG does not routinely discuss the option for them to meet Kassomo.

Kassomo said that when many of his patients first visit him, they already suspect or know they have AIDS. They prefer to visit him instead of the hospital because it allows them anonymity. Kassomo is well known in Tanga for treating AIDS, but since he also treats other things, and has many visitors (not only HIV positive people and not only sick people), clients are more comfortable visiting him where they may just be seen as visitors. This is quite different than walking into the TAWG office where incidental observers and intentional onlookers quickly assume that you have AIDS. In Tanga town, the building that houses TAWG is directly associated with the kitengo cha UKIMWI (AIDS group).

Kassomo, like many healers, has the reputation of providing a confidential service. Some of TAWG’s clients feel more comfortable talking to him than to hospital health workers (including TAWG staff) about their problems—whether they are health or personal problems. Others described the hospital setting as intimidating, impersonal, or non-confidential. Kassomo said that people come to him with their personal problems (including but not limited to HIV/AIDS) because they like and benefit from his style of counseling. He also provides them with plant medicines (the same ones that TAWG distributes and at times additional ones), visits them at home, and counsels them. When appropriate, he also advises family members and caretakers of the client on how to care for him or her properly.

Janzen (1978) and Feierman (1985) have argued that in Africa the therapy managing group is key in determining modes of treatment—whether the provider be a healer or a physician. While “the hierarchic dyad of practitioner and sufferer...is best exemplified by Western medicine, in tradition-derived therapies, the notion of privacy between practitioner and patient is not

found” (Janzen, 1978, pp. 224–225). I argue that the epidemiological landscape has changed the relationship between healers and their patients. In the case of HIV/AIDS, the therapy managing group has often been cut out of the picture by the patient because of the stigma associated with the disease. 41% of the 99 TAWG clients interviewed said that the people they lived with were not aware of their HIV positive status, and 63% said that their neighbors are not aware of their HIV positive status. Clients often insist on anonymity, visit healers alone, and delay telling family members, spouses, and lovers about their status.

If a healer (or physician) fails to convince a patient that the diagnosis and mode of treatment are appropriate, their expertise is of little value. Some patients reject TAWG and the medicines they give because accepting means accepting a diagnosis of AIDS, which is often interpreted as an immediate social death, impending suffering, and eminent physical death. Kassomo has been successful in helping patients and their families come to terms with AIDS and treatment plan when TAWG health workers were unable to do so. The combination of his personal skills, and the expectations people have of him as a healer enables him to succeed in cases when TAWG cannot.

Witchcraft and disease experience

Kassomo said it is not uncommon for a patient or their family to attribute witchcraft as the problem and deny the possibility of HIV/AIDS. This can be easier to accept than the harsh reality associated with the stigma of AIDS. Multiple TAWG client interviews revealed cases when either the client or the client’s family had first suspected witchcraft as the cause of illness before coming to terms with their HIV positive diagnosis. Kassomo’s ability to deal with these clients is quite valuable to TAWG. TAWG requests that Kassomo visit patients who are disturbed (crazy or kichaa) and object to treatment because they believe they have been cursed or bewitched. Although Kassomo does not practice uchawi (witchcraft) or punya mashetani (perform exorcisms) he is able to use his knowledge, sensitivity, and experience as a healer to provide people with counseling and treatment in a way that speaks to their needs and expectations.

For example, Kassomo explained how a client who was kichaa refused to take any medicines, talk to

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20 Although this probably happens less since AIDS education campaigns have been launched, in East Africa witchcraft is thought to be the reason for some people’s overwhelming sickness. The belief in witchcraft is real today in both urban and rural areas. In 2000, at the port of Mombassa, Kenya a large AIDS education campaign banner was posted reading “UKIMWI SI UCHAWF” (AIDS is not witchcraft).
doctors, or take care of himself at all. His family felt sure he was HIV positive and wanted to help him. The patient refused to visit TAWG’s office or the hospital, and when the TAWG homecare team came to his house (at the request of his family), he refused to talk to them, and acted belligerent. TAWG brought Kassomo to visit him and he was able to calm him down, and persuade him to begin using his medicines. The medicines may represent more than just treatment to the patient. They are a public acknowledgement by the patient, healer, and family members that he or she is worthy of care and treatment and not the punishment of sickness and death for committing immoral acts. Using medicines from a healer instead of a doctor, may also deflect personal accountability for contracting HIV, and divert attention to a supernatural etiology.

This is yet another example of how Kassomo has adapted to his community, a community faced with understanding and dealing with the cultural, emotional, and physiological consequences of AIDS. He understands the biomedical model, but talks to patients and their family members in ways that are commensurate with their language, values, and belief systems when the biomedical model and language are not. If a patient anapandisha mashetani (is possessed) Kassomo says that he really has to use his ujanja (cunning) in order to help the patient come to terms with his/her illness and use the right medicines that will not interact with medicines already being taken. Unlike TAWG staff, he knows which plant medicines are compatible with each other and which are not.

**Emerging roles**

Kassomo’s relationship with TAWG and other members of western, scientific, and biomedical communities, represents emergent roles for healers—as liaisons between healers and TAWG health workers, and between patients and TAWG health workers, as well as filling a niche that biomedicine cannot. Although he is unique in his own community, he may be representative of a larger trend in healer adaptation. For example, about a 4-h drive north of Tanga town is a healer who (like Kassomo), has a long relationship with physicians at a hospital (Kilimanjaro Christian Medical Center, KCMC, a large private hospital in Moshi) and has interacted with national and international health policy workers. Both he and a physician from KCMC described their previous research collaborations as well as potential plans for a clinic to be operated by both healers and biomedical health workers specializing in skin disorders and wounds. Like Kassomo, his treatments are botanical based and do not involve spirit possessions.

There are other similar instances in which healers and biomedicine are adapting by exchanging or combining ideas. In 1992 in Uganda, Traditional and Modern Health Practitioners Together Against AIDS (THETA) set guidelines for their collaborative research on AIDS treatment and has continued to be recognized for its productive results in both working relations and in supporting PLWA (THETA, 1998, p. 4). In 2000, a regional task force on traditional medicine and AIDS in East and Southern Africa was inaugurated. Composed of African non-governmental healer organizations (THETA, Traditional Health Practitioners Association of Zambia, and the Zimbabwean National Traditional Healers Association), international organizations (UN-AIDS, WHO/AFRO, and the Global Initiative For Traditional Systems of Health), and West African observer delegations, this group recognizes that “most people with HIV/AIDS use traditional herbal treatments for HIV-related conditions including opportunistic infections” and that not only antiretroviral drugs but also essential drugs are scarce and prohibitively expensive for most people in the region. The task force aims to conduct collaborative research that will “identify, assess, and develop safe and effective local treatments for HIV-related illnesses” and to disseminate this information (Bodeker, Kabatesi, King, & Homsy, 2000, p. 1284).

**Summary and conclusion**

In a conversation about the objectives of healers and physicians, one very well known and respected healer in Tanga explained, “kuna safari moja.” Literally this translates to “there is one trip,” but a more accurate translation is “there is one quest,” which expresses how both healers and physicians share the goal of improving health and implies that they should work together. While not all healers are able to “travel” with biomedical practitioners, Kassomo and TAWG have been journeying together for years.

This research has contributed to a new understanding of healer adaptation by showcasing one who has negotiated a position that straddles the world of biomedicine and the world of healers. Kassomo’s experiences illustrate some of the relevant influences and possible adaptations of contemporary healers. He, like other healers, experiments, invents, and integrates new treatments and ideas into his practices to meet the shifting epidemiological and sociocultural needs of his community.

To say that TAWG has benefited from working with Kassomo (and other healers), understates the fact that it could not continue without a healer like Kassomo. Because biomedicine in Tanga offers neither adequate treatment nor cure for HIV/AIDS, Kassomo’s medicines are the basis for TAWG’s treatment for PLWA. Together with members of the biomedical community,
especially those from TAWG, Kassomo has made legitimate and notable contributions to address AIDS in Tanga through providing treatment for hundreds of people.

Although Kassomo is a pioneer in his own town, he may represent a trend in healer adaptation. His experiences illuminate how multiple factors, especially biomedicine, AIDS, and related research(ers) can influence healers’ adaptations. In his case, biomedical health workers call upon him not only to act as a liaison between their services and the community, but more importantly, to provide treatment for opportunistic infections and counseling for patients and to participate in biomedical and scientific projects. While it is true that Kassomo has adopted aspects of biomedicine, his experience exemplifies an adaptive process that is not unidirectional, with information and resources flowing from the biomedical sphere into the world of healers. It is certainly bi-directional, or perhaps even cyclical.

The trend in collaboration between healers and biomedical health workers has been facilitated by an increased acceptance of healers by biomedical practitioners who recognize the value of healers not simply as trainable village health workers but as people with unique contributions for expanding health services in ways that biomedical physicians cannot, especially with respect to HIV/AIDS. Another necessary factor in developing this cooperative trend is the group of healers who, after decades of criticism and condemnation of their profession from political and medical officials, are willing and interested (if cautious) to develop relationships with biomedical health workers. AIDS clearly is the catalyst for bringing healers, policy makers, and biomedical health workers together. Since working with TAWG, Kassomo has become more well known not just in his community but also in the international community. He has been featured in UNAIDS21 and World Bank reports,22 a British Broadcasting Corporation “Health Matters” program,23 and now in this article.

Biomedical health workers and government officials who express interest in building relationships with healers but believe that “traditional,” “superstitious,” or “non-scientific” (e.g., not formally educated) qualities of healers prevent this possibility have been hindered by a limited understanding of the dynamic and flexible qualities of many healers including their willingness to interact with biomedical practitioners. The attention and resources demanded by HIV/AIDS has brought more healers and health workers together than ever before. Greater understanding of the dynamic role of the healer in Africa can hopefully lead to better care for PLWA.

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References


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21 See King (2002).
23 See British Broadcasting Corporation (2002).