

**HEALING ENVIRONMENTAL HARMS:
SOCIAL CHANGE AND SUKUMA TRADITIONAL
MEDICINE ON TANZANIA'S EXTRACTIVE FRONTIER**

by

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**A dissertation submitted in partial fulfillment
of the requirement for the degree of
Doctor of Philosophy
(Natural Resources and Environment)
in the University of Michigan
2012**

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DEDICATION

This dissertation work is dedicated to my grandparents, parents, siblings, relatives and friends.

ACKNOWLEDGEMENTS

I owe every individual who directly or indirectly supported me in making my journey through SNRE possible, from which my thoughts and ideas coalesced in a form that could be read by others. I thank Professor Rebecca and Professor Bunyan for their persistent and continuous encouragement, motivation and inspiration throughout my doctoral studies. I would like to recognize the former dean at SNRE, Rosina Bierbaum for her consistent moral and material support for my research and my studies at SNRE. I thank SNRE, CAAS, ASC, PitE, the Global Change faculty, and the Rackham Graduate School for their support.

I thank my respondents in the field both healers and non-healers that are too numerous to mention by name for their invaluable contributions and ideas. I appreciate the time they spared to listen, invitations to their homes and work places, and incredible stories, life histories, experiences, and practices they shared with me. I want to recognize some of them on behalf of all the people I interviewed. I thank Busondole Musobi and Mzee Nhimbili Buhimila for interviews and songs. I extend my acknowledgements to various individuals for their collaboration, including members of the Bujora Community for allowing me to review the information and archival data at the Museum, the late Father Sandu, Father Mabura, Richard Buluma, Ms. Bestina, Mr. Mtalingi; the Medical Doctors at Mwanza City Council, Dr. Kimaro, Dr. Mkina, and Mama Tibaijuka; as well as Dr. Kasuka and Ms. Mwana Masalu from Misungwi District Hospital.

I wish to thank individuals who were part of my research team, including Luckness William, Robert Renatus, and William Kayichile. I wish to thank officials working for the village,

district, and regional authorities in Mwanza for welcoming me and introducing me to different respondents during field work.

I thank my mentor and adviser, Professor Rebecca Hardin, for the reviews and inputs to the research proposal to the write-up stage of this document. Professor Rebecca, thank you for all the guidance, inspiration, motivation, advice, support, and reviews of my earlier drafts, as well as offering constructive ideas. I extend my acknowledgements to my committee members, Professor Bryant Bunyan, Professor Kelly Askew, and Professor Nancy Rose Hunt, for their inputs and suggestions. Their guidance has helped me learn and gain new knowledge and skills in the field. Their guidance and motivation have also enabled me to be able to comprehend new perspectives when learning about people's lives and how are they shaped by global phenomena. Thank you, Professor Bunyan for your inspiration, encouragement and humble approach throughout my time at the University of Michigan.

I wish to thank members of DESULICO and many other students at the University of Michigan for their enlightening discussions, constructive criticisms, and contributions. Thank you Professors Arun Agrawal and Rebecca Hardin for hosting DESULICO meetings, which have helped me gather comments and ideas for my dissertation. I wish to extend my appreciation for the support and cooperation I received from the National Environment Management Council and the National Institute for Medical Research of Tanzania. I also want to extend my thanks to Engineer B.T. Baya for the support he gave me and that enabled me to do research in Tanzania.

There are individuals here at the University of Michigan whose contributions have been vital and I extend my appreciation to them. I am thankful for the critical reviews and comments of Shaw Lacy, Ted Lawrence, David Eisenhauer, Jennifer Demoss, M'Lis Bartlett, Jennifer Johnson, Aimee Massey, Sarah Katherine Pethan, Catherine Benson, and Baruani Mshale. I extend my acknowledgements to Dr. Julie Andrzejweski, Dr. John Alessio, Dr. Emma Bailey, and Neema Jangu, and for their inputs in my writings. I thank members of the SNRE, CAAS,

Global transformation and Global Health seminar community for their different roles, and I am glad that I was part of the team.

My writing has benefited from the local and international seminars that I have attended and at which I presented preliminary findings. Internally, I have benefited from supervisors and students involved in seminars on Global Transformations and Global Health. Externally, the seminar held at Omar Bongo University in Libreville, Gabon, during the PSAI-International and Interdisciplinary Summer Training (July 17–26, 2007) on “Entangled Medical Fields: Transformation of Meaning, Knowledge and Practice.”

To my parents, brothers, sisters: thank you for your love and unconditional support and insights about information gathered in the field. I also wish to extend my acknowledgements to my friends, the families of Condon and Makene for their support and encouragement.

I thank the Rackham Graduate School for the financial support that I have received, enabling me to pursue graduate studies in SNRE and CAAS as well as supporting my field work abroad. This Institutional-Review-Board-approved field study in Tanzania during the summers of 2006, 2007, and 2008 as well as extended periods of field work between June 2009 and August 2010 was made possible through support by the Yossi Schiff Memorial Scholarship, the School of Natural Resources and Environment Dissertation Research Grant, African Initiative Grants and Fellowships, the African Studies Center Fellowship, and the Rackham Graduate Research Fellowship.

Menan H. Jangu

Winter, 2012

PREFACE

Having been born and raised in the Mwanza region, worked in beverage and food industries and with an environmental institution in Tanzania and conducted my dissertation research in the region between 2006 and 2010, I have observed and recorded different dynamics and interactive processes in politics, economics, culture, environmental management and epidemiological conditions over time. In the 1980s, I observed major events happening in Mwanza that have continued shaping health, environmental and economic conditions. The major industry at that time was the government owned Mwanza Textile (Mwatex), which obtained its raw material from cotton grown in Sukumaland. In addition, there were ginneries and vegetable oil industries that were owned by the Nyanza Cooperative Union. In the mid-1980s Nile Perch started appearing in the local market, and people were amazed by the new species that soon dominated the market. The presence of Nile perch in Lake Victoria occurred at the time when the government was transitioning from socialist ideas to privatization and free trade policies.

Fish industries were built fast and quickly started processing fish for the European market. These industries used advanced fishing technologies which jeopardized the ability of local and artisanal fishermen to access lake resources. Likewise, during the same period the mining activities that were operated by artisanal miners were also transformed as many investors scrambled to secure land in order to invest in mining.

Local people and artisanal miners in mining areas were forced to relocate. This condition has aggravated social tensions and conflicts over land in the region. Personally working in one of the beverage industries in Mwanza, I could observe shortage of domestic water for local people, but the industry rarely stopped operating due to water shortage. In other words, resources such as gold, fish, water and land in Lake Victoria basin became focal points of contestation between investors and local people.

Again, during the same period (1980s) the region experienced a new emerging disease, (HIV/AIDS) and people were confused by its symptoms that could hardly be treated by either biomedicine or traditional medicine. This was the time when the local militia, Sungusungu vigilantism, was spreading through Mwanza in response to crimes such as robberies, witchcraft, and brindigadge. Because of these and other forces, Mwanza was dramatically transformed on multiple fronts including economic activities, land use, investment, security affairs, politics, and epidemiologically. Likewise, in some spaces, in the outskirts of Mwanza (Nyamhongoro about 9 kilometers from Mwanza town), used as grazing fields, and some space hosting healers who preferred to live in isolated places. Since then areas once considered isolated have been converted into residential areas to accommodate the increased population in Mwanza. By the 1990s the textile industry was almost abandoned and Mwanza was dominated by fish and mining industries. At the same time the magnitude of HIV/AIDS effects were alarming in their devastation to the community. With my undergraduate degree in Chemical and Process Engineering I had been working in industries for most of the time, yet I felt limited in understanding social processes occurring in Mwanza. I felt that social problems in the region were intractably linked to the presence of resources and how these resources were

managed. I observed community members struggling with deciding between biomedicine and traditional medicine while responding to rapid changes in health conditions with emerging diseases such as HIV/AIDS. Because, I was intrigued by rapid changes taking place, I decided to seek employment with the National Environmental Management Council as a way of better understanding the transformative process taking place. This unique experience exposed me to a wide range of issues and gave me an opportunity to link health, environmental and medical practices as my area of interest. I started developing an interest in the roles of healers and notions of medicine as I could see diverse groups operating in different setting such as rural versus urban. I wanted to examine their role in Mwanza and the services they can offer in responding to health and environmental changes happening in the region.

This dissertation engages traditional healers ethnographically to examine the intersecting dynamics of culture, demographic change, environmental change, environmental risks, health burdens, and transformations in traditional healing practices. In order to understand these processes, I examined healers' perceptions and practices. Traditional healers are well-positioned to observe ongoing environmental change and to reflect on those changes as they are expressed within cultures, as well as their own relationships to local definitions of health and healing. More than 80 percent of the population consults traditional healers for health and security needs. Likewise, healers themselves assume different roles in society apart from practicing medicine. They are the farmers, livestock keepers, medicinal collectors, song composers, leaders of the dancing groups, and support group in political processes. Therefore, healers are in good position to understand and explain changes that are taking place in society.

To study how traditional healers conceptualize and adapt to the socioeconomic and ecological changes happening in the Lake Victoria basin, I used both phenomenological inquiry (collecting and identifying phenomena as they are perceived and understood by different actors in the region) and an ethnohistorical approach to understand healers' therapeutic languages, symbols, perceptions, expressions and practices in relation to socioeconomic, environmental, health changes. By exploring changes in medical perceptions and practices by healers over time, my research gathered information on four constitutive sub-themes of medical practices as they link to healing: livelihoods, therapeutic and marketing practices, rituals and broader political social interactions with communities and the state.

My analysis examines both the inter-cultural and cross-cultural therapies involving different actors struggling with and adapting to political and environmental changes in Mwanza. I collected data in summers of 2006, 2007, 2008 and during extended period between June 2009 and August 2010. The data were collected by interviews from 15 villages in 5 districts (Ilemera, Magu, Misungwi, Ukerewe, and Nyamagana) within Mwanza province. During my extended stay in the region (June 2009 – August 2010), I contacted a previously identified network of informants and familiarized myself with newly-identified traditional healers, entrepreneurs, and customers of traditional healers during the extended field work. There were thirty (23 percent) healers out of 130 who were interviewed twice. My research involved interactions with both registered and unregistered traditional healing practitioners. I contacted elders and other village governing bodies to identify medical practitioners who

were not registered as well as contacting the district and regional medical offices to seek information about registered healers.

With respect to registration, it bears mention that I conducted fieldwork at the time (2007 – 2010) when people with albinism were attacked and murdered for their body parts - reported to be ingredients for luck charms in mining and fishing industries. Healers, artisanal miners and fishermen were accused as seekers and traders of albino body parts. These events coincided with the theme of my research that examines healers' changing perceptions and practices in relation to changes that are happening in society in terms of economic, culture, ecology, and politics. The violence against people with albinism became another area of inquiry for my research in two ways. First, healers were my target response group, but their activities were restricted by the government and their licenses revoked for accusations that they were culprits of violence against people with albinism. The exercise to register healers, which was initiated in 2006, was suspended in 2009 following the accusations that healers were implicated in violence against people with albinism. This affected healers' responses as they did not want to incriminate themselves as being involved in crimes. Rumors were common that undercover investigators of albino killings were posing as clients of traditional medicine or researchers in order to gain access and investigate healers.

Second, this not only affected the ways in which I collected my data, but also became an area of inquiry in critically examining the influence of evolving societal perceptions and practices of traditional medicine, crimes and legal systems. Data obtained through interviews with healers were examined by triangulating with other sources of information, such as interviews with legal experts and analysis of the court

cases related to violence against people with albinism. Legal experts were interviewed to examine how the legal system in Tanzania deal with crimes that are linked to traditional healing practices and witchcraft. Additional interviews were conducted with individuals working for the agencies supervising children with disabilities including those with albinism.

The research was conducted after obtaining an IRB approval from the University of Michigan and the National Institute for Medical Research in Tanzania. Other approvals were obtained from the National Environment Management Council of Tanzania. The interviewees were informed using the consent form about the purpose of the study. The purpose of the interviews was to gather lived experiences of both healers and non-healers. I also received an introductory letter from the District Offices that introduced me to the ward and village authorities where I conducted interviews. At the regional, district, and ward offices, I reviewed rosters of registered healers in order to identify candidates for interviews and discussions. In other words, the respondents in this study were identified through 1) records available in the district and ward offices based on what they have indicated as their specialty, 2) the network of informants who were consulted during preliminary work in 2006 – 2007 in the region, and 3) information from the village authority and agencies working with groups of traditional healers like that of the Bujora Sukuma Cultural Museum Center in Kisesa Mwanza.

Undertaking this research acknowledges various groups within the field of traditional medicine. Traditional medicine is a subset of healers' livelihood, and its existence is embodied in what healers are doing on several interconnected fronts: farming, livestock keeping, entertainers, security providers and citizens of the society.

My selection of respondents thus recognizes a broad range of experiences and reflects the transformation of healing practices as responses to changes happening in the environment and social structures. The sampling process unfolded in “snowball” fashion, and emphasizes the existing diversity and complexity of cross-cultural medical practices in the region involving various groups of healers such as herbalists, midwives, diviners, bonesetters, vendors, and medicine collectors. By spending time with healers, medicine gatherers and sellers, clients of traditional medicines, and representatives from government agencies, I conducted 211 semi- and unstructured interviews and collected life histories regarding health challenges, medicinal resources availability, development programs impacts, and political processes and transformations. Most respondents were Sukuma, the dominant group in Mwanza. But other interviews involved ethnic groups operating in Mwanza including, Maasai, Nyamwezi, Waha, Kara, Kerewe, and Kurya. There were old and young healers; women and men; and registered and non-registered healers who have been instrumental in providing much needed information for this work.

In addition, I carried out participant observations and recorded an initiation ritual by a healer that was performed for two days, and eight days of competition among Sukuma dancing groups in 2006 and 2007. I collected the ethnographic data using written notes, audio and video recording, and photographs upon consent of participants. I was accompanied by research assistants who were familiar with the area and cultures. I worked with students from St. Augustine University (T) and a retired medical assistant who had worked on a similar kind of project in the region.

I conducted the field work in multiple sites and interacted with various categories of traditional healers in different settings using Swahili and Sukuma language, both of

which I am fluent in speaking and writing. The knowledge of these languages and my general familiarity with the region helped me build trust with the interviewees. The total number 130 healers in five districts of Mwanza region were interviewed in both rural and urban areas, purposely to account for the demographic, social, cultural, economic and environmental factors shaping medical perceptions and practices (Aikins, 2005). Among them there were ten healers who occupied leadership positions in Sungusungu, and five healers were *balingi* (song composers, and leaders of Sukuma dancing groups). Interviews were undertaken with different groups of healers to construct both individual and collective meaning of epidemiological conditions, healing, and security affairs in the region. The purpose of interviews was to establish an “oral history archive” that explains the experience of transforming traditional medicine. Similar approaches have been used to capture narratives of the medical practitioners about their first responses and understanding of the HIV/AIDS epidemic in the United States (Bayer and Oppenheimer 2000). Another set of interviews involved forty-two consumers of medical services and biomedical practitioners in the district and private hospitals and rural health clinics. I also conducted interviews with forty people that represented members of the in the villages, officials in health and environmental institutions.

The majority of the interviews took between 45 minutes and two hours. Other interviews totaled for more than three hours but were performed in multiple sessions. Along with interviews, I collected life histories in order to understand the trajectories in which one becomes a healer and how they respond to the clients’ needs over time. The data from healers were corroborated with data and information from other groups of respondents including community members, leaders of Sukuma dancing groups, and

leaders of locally initiated security groups, Sungusungu. Other interviews were conducted with representatives from health and environmental institutions, including Sekou Toure Regional Hospital, the National Institute for Medical Research, the Water Laboratory, and the Lake Victoria Environmental Management project. Respondents in this document have not been identified by their actual names, but by pseudonyms. Further, I conducted participatory observation and informal discussions in order to capture and interpret social expressions, processes, and practices between individuals and between groups of people.

I held four group interviews and seven focus group meetings with traditional healers and societal members in an attempt to account for differences in instances where insufficient individual accounts or individual opinions might have skewed data (Waite, 1992). I facilitated the interactions through video screening to the healers at Bujora Sukuma Museum in Mwanza regarding experiences of traditional and medical practices in other countries in Africa. The video screening of the two documentaries: *Healers of Ghana*; and *Sangoma in South Africa-Traditional healers in modern society* had a positive effect. Respondents acknowledged this mechanism of sharing knowledge and learning experiences from other countries as a result building more trust with a researcher. Respondents were more positive and willing to provide their reciprocal revelations.

I followed two healers and observed and recorded their practices, such as the collection, preparation, and administration of traditional medicines in rural areas. I also observed healers selling medicine in *gوليو* (flea markets) and in Mwanza city particularly for Maasai healers. In addition, I observed Sukuma dances organized by the Sukuma Culture Center at Bujora in Mwanza in June 2006 and June 2007. Sukuma people have

historically described events using oratory description in songs that are featured in different dancing groups (Gunderson, 2010). Therefore, to capture details of political transformation in the field of traditional healing practices, I asked song composers for permission to record their songs for further analysis. In the process I was able to collect twenty songs. Some of them appear in the chapters to follow. The research also involved observing ceremonies to initiate healers, performances of Sukuma dancing groups involving individuals with medicinal knowledge, and healers' activities and their interactions with their patients.

Archival data related to Sukuma traditions were collected from the Sukuma Cultural Center at Bujora in Mwanza. These materials include Cult of Ancestors collection (Sukuma Archives Bujora M-SRC45); Chiefdoms in Sukumaland, History of Sukuma people and healing practices; Initiation of Chiefs, Kingship organization, Names of the diseases and their symptoms, plant and animals' species and their functions. In addition, daily Tanzanian newspapers were thematically collected and used as sources of information about healers and community members' perceptions of traditional healing practices in contemporary setting. In my field work, I collected data on different aspects related to traditional healing in Mwanza that included Sukuma culture and traditions; healers' understanding of the magnitude of health problems such as HIV/AIDS in the region; the impacts of health policies on healing practices; how both traditional healers and biomedical practitioners respond to health and medical needs; traditional healing and health policies; changing environmental and economic conditions and the way they affect traditional healing practices; the role of traditional medicine on the violence against people with albinism; the impact of development programs-Ujamaa villagization on

healing perceptions and practices; efforts by healers to reclaim of identity and authority through the establishment of Sungusungu vigilantism; power struggles between different groups of healers, and the entrepreneurship and networks of therapies.

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ABSTRACT

Mwanza, a border zone of Tanzania, on the south end of Lake Victoria, is at the center of a transportation corridor of extractive industry and export oriented economies. Historically the area was a center of the Sukuma group, an amalgam of various immigrants over time who are brought together by traditions of healing that link to collective rituals as well as to agricultural and pastoralist prowess. The recent explosion of the commercial fishing and gold mining industries in the region has dramatically eroded people's landscapes, and altered social structures and migratory patterns of labor. The first section of the thesis documents traditions in Sukuma subsistence practices as these link to traditional healing and patriarchy, chronicling transformations wrought by colonial, socialist, post-socialist, and neoliberal political economies within Tanzania over the last century. The second section captures a paradox: factors driving an increasing need for traditional medicine at the same time inhibit its practice, and transform its legacies. The prevalence of HIV has led to new modes of commercialized traditional healing, with storefront remedies and new floral and faunal components. However, new social tensions are eroding the socially embedded rituals that intrinsically link physical healing with political and spiritual leadership. The threats to traditional medicine (e.g. criminalization, climate-driven migration of non-local healers and their remedies, loss of biodiversity and conservation related restrictions) are greater than ever. Overall, the study thus contributes to scholarship on healers and magico-political leaders in East

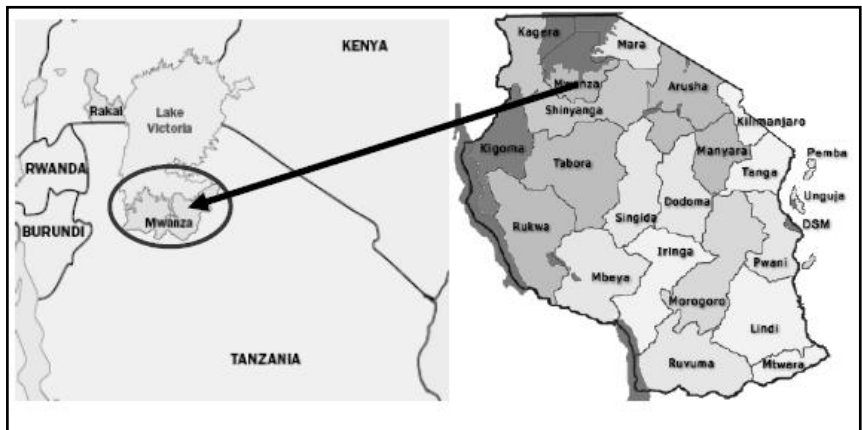
Africa, but also to emerging work on African environmental justice issues, by addressing Mwanza's traditional healers as key players in systems of nested and interconnected vulnerability to environmental and economic change.

INTRODUCTION:

CHAPTER 1 ENVIRONMENTAL IDENTITIES, JUSTICE AND SOCIAL CHANGE IN MWANZA, TANZANIA

The Mwanza area of Tanzania (Figure 1), at the southern end of Lake Victoria and near to neighboring countries, has long experienced radical socioeconomic and environmental changes caused by climate change, political decisions, and rapid in-migration to the

region. Since the colonial period, this region has been recognized as rich in renewable and non-renewable



The **Figure 1: Locating Mwanza, Tanzania**

Mwanza region has been dominated in the past by agrarian practices but has transformed into mostly intensive resource extractive industries. These transformations have created influxes of actors in different sectors as mining and fishing thus creating demographic changes. Mwanza is currently the biggest exporting region of filleted fish in the Lake Victoria basin, and has gold reserves that have attracted local and external investors. In

contrast to this background of great natural wealth, the majority of the people in Mwanza are poor. For instance, the average per capita for Mwanza Region in 2004 was recorded in the amount of TSH. 180,000 which is equivalent US\$ 120 (Mwaipopo, Mutagwaba et al. 2004). The previous studies in the region indicate the average household income of TSHS 30,000 (equivalent to US \$20) per month (Whitehouse 2002). These people now have to bear the health and environmental damages caused by industrial activities. Fish industries, most of them located on the lake shore discharge their effluents in the lake, thus diminishing the quality of water.

Transformations happening in Mwanza were portrayed by the documentary *Darwin's Nightmare* directed by Hubert Sauper released in 2004. The film aroused public interest in questions surrounding the nature of globalization in Africa, and made clear the political stakes involved in Mwanza's social and environmental and dynamics. The film also reveals the way that events in Mwanza stand in for dilemmas faced on other economic frontiers, where epidemiological and environmental consequences of economic change are causing many to question particular forms of globalization. These conditions contribute to the decline of food production and increased incidences of diseases. These factors affect medical conditions leading to the increased demand of therapeutic interventions, as shown by the increased demand for and consumption of biomedicine, traditional medicine and natural products.

The region is widely dominated by the Sukuma group, with more than six million people. They are the largest ethnic group in Tanzania. Sukuma society is characterized by song and dance performed during ritual ceremonies for childbirth, death and work (Mirambo, 2004). The population in Sukumaland lives in both rural and urban areas, but

often close to water bodies and roadsides (Flynn, 2001). Historically, the Sukuma have engaged in agro-pastoralism, owning large cattle herds. However, the persistent recurrence of drought in many places, combined with a lack of adequate grazing space and disease infestation, has reduced the viability of owning large cattle herds. Crop agriculture in Sukumaland, focusing primarily in cotton, maize, cassava and rice, also constitutes an economic livelihood and social identity (Madulu, 1998). In recent years, Sukuma living conditions have changed dramatically as a result of both naturally-occurring and human-driven change. Changing environmental conditions as well as the introduction of cash crops such as cotton, have adversely affected subsistence farming and the natural environment. People in Sukumaland increasingly opt for other activities such as working in industries and other informal jobs.

Environmental conditions and social processes impact people's health and traditional healers' spatial arrangements in many different ways, as well as their access to medically-important flora and fauna. The combined environmental and health issues in Mwanza, Tanzania are producing far-reaching social and political effects that are only now beginning to receive adequate anthropological attention (De Waal 2006; Fassin 2006; Ferguson 2006). Mwanza, like other urbanizing cities in the developing world is recording numerous health changes on multiple fronts such as diseases that are directly linked to poverty or affluence, infectious diseases such as HIV/AIDS, and communicable diseases related to living in a contaminated environment. These health challenges have overwhelmed the existing medical facilities, and created opportunities for healers to intervene using their knowledge to support health programs. Consequently the region has become the hub of different groups of healers with different ethnic backgrounds

competing and complementing one another in the field of therapeutic interventions that are aimed to respond to ills in health, economy, security, and social affairs. The Mwanza region not only attracts local and external investors in the widely recognized businesses of mining, fishing and tourism, but also entrepreneurs in the field of traditional medicine. The increasing migration of people into the region both reflects and reveals the epidemiological crises there. Mwanzan healers and their patients are seeing the traditional healing system transformed into bigger business, rituals proliferate and in some cases coincide with violence. My analysis suggests that traditional healing is not only a provision of therapeutic services, but also a crucial form of cultural identity and expression that responds to socioeconomic and ecological transformations, and links to security affairs in a cross border context.

Understanding the spectrum of change and continuity in traditional healing, then, is crucial to understanding the range of endogenous and exogenous opportunities available for building better health care delivery, and building it in ways that relate and respond effectively to the broader environmental and social processes shaping health challenges. I move this discussion to the particular region of Mwanza to examine the role of healers as they respond to epidemiological crisis while at the same time adapting to changes happening in the Lake Victoria basin.

Many regions in the world now have become vulnerable to health and environmental risks, thus provoking the debate about risky society, and the need for environmental justice (Spiegel 2009). Likewise, the intensification of economic activities, exploitive and extractive industries have become focal points for the research on “risky capital investments” (Emel and Huber 2008). Mwanza represents one of those sites based

on the intensification of industrial activities with inadequacy of a stable and efficient infrastructure system. The region has recorded numerous health and environmental challenges. While many possible solutions to Mwanza's health dilemmas can be imagined at the policy level, the area's changing traditional healing sector offers, to many residents, the most accessible solution to these intertwined social and environmental ills. Like anywhere else, health and therapeutic methods in Mwanza have long been shaped by historical, political, cultural, and ecological conditions. The medical practices in Tanzania vary widely, and are often categorized as either "traditional" or "western." Traditional medical practices include methods of healing using rituals, natural medicines such as plants, herbs, and animal parts. "Western" medicine entails technologies not often afforded poorer communities, and include synthetic drugs (Marsland 2007). The existence of both types of medical practices in the region creates complementarities and considerable conflicts in people's choices for health and medical care.

Chronically ill people in Mwanza have often been 'hedging their bets' by applying both traditional and conventional types of medicine when suffering from illness (Marsland 2007; Langwick 2008). Often times the sick seek out traditional healers solely because they cannot afford the biomedical option (Muela, Mushi et al. 2000; Hausmann Muela, Muela Ribera et al. 2002), but research on malaria, HIV/AIDS and other infectious diseases has also shown that chronically ill people often go to hospitals when traditional methods have failed (Pilkington, Mayombo et al. 2004). On the other hand, some studies have shown that ill people consult traditional healers for chronic diseases when biomedical interventions have failed (Murray and Rubel 1992). My study moves beyond the debate surrounding the intersection between multiple therapeutic frameworks,

documenting widespread integration, and examining the impacts of political and environmental change to the traditional healing beliefs and practices. Traditional medicine in this context is more than attending physiological and mental aspects of health, and accounts for health in a broader context of livelihood, security, economic aspects, and environmental conditions. In a situations like this, healers for their multiple functions and spiritual connection are seen as saviors to address health, social, economic and security challenges in communities. In contrast, however, healers themselves are not immune from vulnerabilities caused by political, economic and environmental changes that are influenced by local and globalization forces. They are also vulnerable to changes happening in the environment and policies aimed at protecting threatened biological resources that are widely used in traditional healing practices. This thesis discusses the way in which these transformations are reshaping health conditions and restructuring medical practices in Mwanza.

My central question is about how healers conceptualize and adapt to the political, socioeconomic and ecological change happening in the Lake Victoria basin. I study transformations in traditional medicine markets, products, and practices. I use an ethnographic approach to understand healers' therapeutic languages, symbols, perceptions, expressions and practices in relation to political, socioeconomic and environmental changes. The study conveys people's vulnerabilities related to health and ecological changes as they seek solutions from healers who are also experiencing vulnerabilities to new markets, their entrepreneurship in creating new commodities and client relationships, and their roles as social and institutional mediators in the face of change.

Little research has been done to examine how medical institutions negotiate and respond to social and health crises that are linked to economic and ecological transformation. The transformation in the field of traditional medicine in Mwanza is similar to what is happening in the developed world. For instance, the consumption of natural products has dramatically increased in the United States with the business largely capitalized and centralized. This shift is evidenced by the increased supply and consumption of supplements and other natural products. Studies indicate that the number of visits to complementary

and alternative providers has surpassed the number of visits to conventional primary care physicians in the United States (Pesek, Helton et al. 2006). I argue this increase is to the large extent associated with globalization

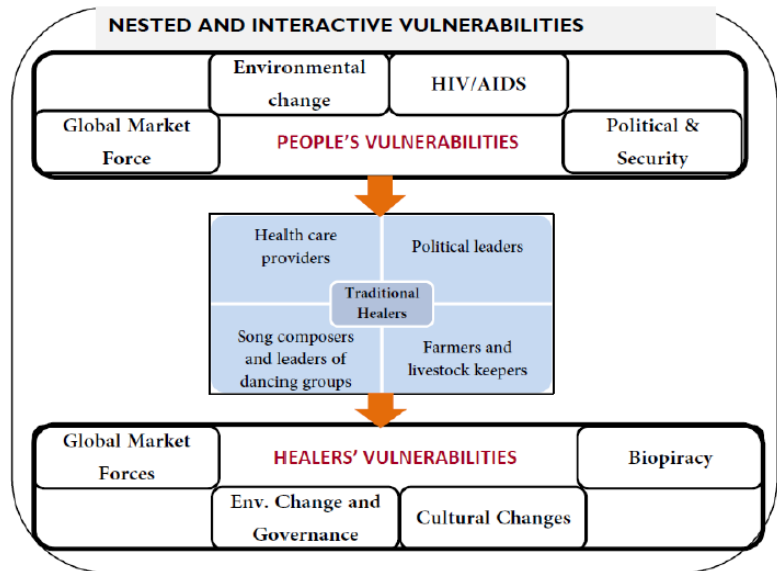


Figure 2: Nested and interactive vulnerabilities in Mwanza, Tanzania

processes that involve massive diffusion of information on alternative medicine and integration of different ethnic groups who have varied cultural beliefs. The increase is also associated with the health challenges of the 21st century that are characterized by living in polluted environments, ingesting contaminated food, drinking polluted water, and new forms of lifestyle necessitating involuntary life changes to mention a few.

In order to explain the dynamic between vulnerabilities of different actors, I use a nested and interactive vulnerabilities framework (Figure 2). This approach helps explain how changes happening in social conditions and the environment create vulnerabilities for the people, who respond by seeking short and long-term solutions from traditional healers who are also vulnerable to political, economic and environmental changes. In other words, the situation in Mwanza demonstrates how different actors influence one another and are subjected to the same nested and interactive vulnerabilities. In a situation like this attaining a sustainable goal such as improving people's livelihoods becomes hard to achieve.

Resource exploitation and ecological marginalization are linked to nested and interactive vulnerabilities that include health risks, environmental damage, violence and people's displacement (Adger, Eakin et al. 2009). Since colonial periods by Germany (1889- 1916) followed by Britain (1916 – 1960) until the time in which Tanzania gained independence in 1961, political decisions, climatic conditions and global industrial capital have transformed the ecological landscape in Mwanza. The region is now experiencing a range of environmental problems including deforestation, land use and land cover changes, loss of biodiversity, and increased pollution levels in air, water sources and soil (Spiegel 2009; Bose-O'Reilly, Drasch et al. 2010). The overuse of natural resources leads to ethno-politically motivated conflicts in combination with certain geographical and climatic factors (Baechler 1998).

The nested and inter-causal vulnerability framework helps to bring together disciplines such as anthropology, political ecology and environmental justice to explain, for instance, how and why a high prevalence for HIV and violence is concentrated along

transport corridors, in urbanizing areas, or those areas with rural extractive industries. This approach also helps to examine multiple functions and vulnerabilities of different actors such as traditional healers in Mwanza. The studies of the region have examined traditional medicine from merely health as a separate entity from the structure of livelihood for healers in which traditional medicine is embedded. Numerous studies from ecological, economic, medical, and public health points of view in the Lake Victoria basin fail to acknowledge the extent to which traditional healers assume critical combined roles in society.

Healers have lived experiences because they interact with clients/patients on a daily basis thus they are capable of observing and responding to epidemiological changes. Likewise, they interact with the environment in their search for medicinal materials and when undertaking rituals. They bring these lived experiences into the songs they compose to entertain people. Therefore, healers form an important group that can explain changes happening in the society and the environment. Despite high demand for traditional medicine due to epidemiological crises and socioeconomic problems, traditional healers now experience significant competition from each other as well as from drug companies. Likewise, healers have to respond to the political processes, environmental changes and emerging conflicts with global conservation programs that advocate protection of biodiversity. With the advancement in biomedical science and technology, societies experience fragile conditions that have elevated the demand for both biomedicines, complementary and alternative medicines.

My ethnographic work conveys details of everyday life, conversations, and rituals in order to reflect on the transformations taking place in Mwanza, thereby illuminating

three constitutive sub-themes of landscape and natural resources as they link to the healing (environment), therapeutic and marketing relations with patients (or clients), and broader social interactions (or communities). My research provides an opportunity for the subjects (traditional healers and other respondents) to speak about their experiences within the broader context of structural and institutional forces for change in their society. The study uses archival research, participant observation, focus group interviews, unstructured interviews, and life histories to identify and analyze the links between economic, population, environmental, social, health and therapeutic related changes.

The ethnography of changing collective and individual healing practices is offered against a historical backdrop that traces how the Tanzanian state formation, extractive industries, climate change, and attendant in-migration have shaped both health problems and the solutions offered to rural residents by Mwanza's traditional healers. A medical landscape in Mwanza, as in many other regions in Tanzania, was first reconfigured by local conditions (spatial arrangement of the people, diseases, and social structure). Colonial intervention created new landscapes of diseases (e.g. concentrating people), health care and medical services by introducing biomedical expertise. Now conditions such as HIV/AIDS, climate change, and social-economic changes are creating new forms of medical problems, perceptions and practices. The influx of different actors, interventions and activities since the colonial era to the present in Tanzania has influenced different medical conditions as well as the perceptions of medical therapies.

I cover shifts in political, economic and social changes by examining the transformation of socially embedded healing practices in the rural hinterlands from which many current Mwanza residents originate, in relation to the commercialized healing

practices on this urbanizing economic frontier where storefront “quick fixes” are popular when those in a search for wealth and power, and with limited income face rising HIV-AIDS rates. Of concern, however, are mounting pressures on these ritually expressed healing practices, at a time when structural challenges such as economic change, environmental scarcity, and epidemiological crisis are at an all-time higher in Mwanza. In other words, the region is subjected to persistent economic, ecological, political changes that erode socially imbedded practices at the time when structured and nested vulnerabilities are increasing.

Existing studies in the region have paid particular attention to the individuals affected by developmental projects as the victims of environmental injustices and structural violence.¹ Lockhart (2008) and others, for instance, reveal how child abuse represents the magnitude of violence happening in Mwanza. Other studies have prioritized epidemiological conditions that affect people in the region (Clift, Anemona et al. 2003; Mwanga, Magnussen et al. 2004). There is scarce information, however, about the links between inter-cultural activities and medical practices in relation to political, socioeconomic and environmental change. Moreover, little research has been done to examine how medical institutions negotiate and respond to social and health crises that are linked to the nested vulnerabilities that to the large extent are determined by economic and ecological transformation happening in Mwanza. Given changes that have occurred, the Mwanza area in the Lake Victoria basin forms an appropriate site to document the reconfiguration of traditional healing practitioners in response to radical

¹ Structural Violence refers to the institutionalized practices that have adverse effects on people. They are the practices embedded in political, economic and social structures that and impede some groups of people from realizing their full potential (Farmer, 1997)

socioeconomic and environmental change. It is a site where health issues and therapeutic interventions are discussed beyond cultural process to include economic, political process, security, and environmental change.

PLAN OF THE DISSERTATION

In order to explain the transformative process in the field of traditional medicine, the dissertation is divided into three distinct sections: 1) histories and theories of health, healing, security and violence in social and political processes during post-colonial and post-socialist periods in Tanzania. 1) characterization of contemporary economies, epidemiological crises and theories in Mwanza and visibility of healing practices and 3) ecologies and visibility of healing practices. These sections are further divided into eight chapters as described below.

Chapter two captures the critical roles of the Sukuma people and traditional healing from precolonial times. The Sukuma healers have long played an important role in Mwanza, practicing herbal healing and different divination rituals that embody livelihood, production activities and maintenance of health. These rituals stem from historical, cultural and adaptations to the natural environment. Traditional healers also assume different roles in society such as political leadership, and for many years they have been credited with influencing social cohesion (Gunderson, 2010; Wiljzen and Tanner, 2002). This social structure, however, is changing due to an influx of diverse groups into the region. Sukuma healers now compete with healers from other regions to attract more customers. This chapter discusses the dynamic and interactive processes between Sukuma (the dominant ethnic group) with other ethnic groups who practice

medicine in Mwanza. Narratives from people in the region demonstrate how the Sukuma's reliance on livestock keeping, farming and fishing is changing in response to conditions such as climate change, the influx of economic activities in the region, human migration, urbanization, natural resource extractive industries, and HIV/AIDS.

Chapter three discusses how political and development policies and practices intentionally or unintentionally contribute to the transformation of traditional healing perceptions and practices. In particular, this chapter discusses the impacts of the government induced displacement and relocation of the people in the pretext of development program famously known as Ujamaa villagization. The forced displacement of peoples tends to disorient communities that had achieved certain level of stability. In the new settlements, new cultures and forms of livelihoods are created. I present how healers have been affected, and their medical landscape altered due to the state formation and creation of nucleated societies. The chapter covers aspects of how the Ujamaa villagization program created a particular trajectory of traditional medicine and the geospatial knowledge of healers on health, diseases, and medical practices. I use narratives from healers and non-healers to examine the impacts of the Ujamaa program on traditional healers. Results show that many were harassed, marginalized and criminalized to the extent that many abandoned their healing practices. The positive and negative impacts of Ujamaa villages appears in the literature, however the extent in which the Ujamaa program affected the field of traditional medicine at that time and in the contemporary settings is missing.

Chapter four looks at the unique social movement Sungusungu whose major strategy of empowerment was the use of traditional medicine to mobilize people and

energize the movement. The use of traditional medicine as a social force is seen as a mechanism that allowed the people to reclaim their identity as an autonomous people which was challenged by the former colonial government and the present central government. The Sungusungu is defined by its use of traditional medicine and is seen as a non-traditional tool for influencing a political process. The Sungusungu movement was largely seen as a success which restored social order between the community and the central government. Analysis of the Sungusungu movement and its central component of traditional medicine are useful in contextualizing a collective identity, and the maintenance and formation of societies in times of crisis and change. This chapter captures the discourse of traditional medicines in relation to crimes and security in Tanzania by using data from court cases, legislation on security matters, and secondary data from human right reports and media sources. Sungusungu emerged within communities as a social movement and reveals that traditional healing is a major influence within this movement through legal paradigms to occupy space in societies despite efforts by colonial and postcolonial governments to restrict its presence. Further, this chapter captures stories of people who have worked in the Sungusungu social movement and the way they embraced traditional medicine as a mobilizing tool for protection, security and social cohesion in communities. I argue that the use of traditional medicine elevated the power and strength of traditional healers in societies.

Chapter five addresses Mwanza as a politically and economically contested region where nested and interactive vulnerabilities are linked to environmental justice. I discuss in the nested and interactive vulnerabilities happening in Mwanza which are the drivers for the demand of traditional medicine. I examine how globalization and the

expansion of extractive industries have impacted health and healing landscapes in the region. Globalization pushes many countries in the global South to create access to resources, labor and markets for developed nations. Trade-liberalization policies introduced in the early 1980s attracted foreign investors, and Tanzania is now ranked the third largest exporter of gold in Africa (Yager 2007), with more than 90 percent of gold reserves concentrated in the Lake Victoria basin in what is called Lake Victoria Gold Field (Spiegel 2009). Although mining activities in the region have increased, the economic opportunities for local communities have decreased dramatically. Similarly, the fish industry on the shores of Lake Victoria, Tanzania, has dramatically expanded during the 1980s with the introduced exotic Nile perch fish (*Lates niloticus*) Nile Perch, similar to the gold industry, has attracted both domestic and foreign investors who aim to process fillets for export to Europe, Asia, and the United States. The higher demand for Nile perch production transformed the Lake Victorian basin from a region relying on multi-species production to one depending solely on few species, and subsequent dramatic changes in ecology, economy, human diet, marginalization of local fishermen, a decline in subsistence fishing and change in human migration patterns (Eggert and Lokina, 2004; Simonit and Perrings, 2005). The presence of these extractive industries is now associated with increased risks of diseases such as HIV/AIDS and violence such as albinocide, child labor.

Chapter six addresses how the HIV/AIDS epidemic is shaping medical practices in a context of rapid intertwined environmental and socioeconomic changes. The discourse surrounding traditional healing is now largely defined by the HIV/AIDS epidemic. The magnitude of HIV/AIDS means it must be recognized as a key factor

affecting patterns of health care use in the region, especially in fostering the simultaneous use of biomedical and traditional remedies (Muela, Mushi et al. 2000; Jones 2006). Integrating anthropological and political ecology frameworks helps explain how and why the high prevalence of HIV is concentrated along transport corridors, in urbanizing areas or those with rural extractive industries. Rather than focusing on a particular sector, such as mining and fisheries, this chapter examines subsistence shifts more broadly, focusing not only on what traditional healing offers in HIV/AIDS treatment scenarios, but on what the changing socioeconomic conditions and environmental landscape and HIV/AIDS transmission discourses can reveal about the role of traditional healing.

Understanding the influence of shifting social networks under changing economic and ecological conditions is crucial to analyzing how such shifting landscapes impact medical-care and disease transmission. Therefore, the chapter examines the debate about micro and macro processes to examine the intervention programs on preventive and curative approaches while investigating the need for creative and locally appropriate responses to the grave health impacts of social and environmental change that aggravate the impacts of HIV/AIDS. This chapter demonstrates how the extractive industries are creating risky environments and trajectories for HIV/AIDS transmission and the way in which the epidemic is socially constructed. In the discussion, I connect migration, labor, and HIV/AIDS with Mwanza's traditional healing sector, and integrate anthropological work on Tanzanian health problems and healing practices with emerging notions of structural violence, international environmental and social justice.

Chapter seven explores the widely published violence against people with albinism that has been reported in the Tanzanian and international press in 2007-2010.

This chapter argues that while both visible and invisible forms of violence against albinos reported in Tanzania occur in the context of ‘resource violence.’ However, such violence must also be understood in light of broader historical and contemporary criminalization of traditional medicine as it relates to beliefs regulating ‘resource access’ Further, I note that albinos engage theories of racialized political identity in unique ways, and help explain changing concepts of marginalization, discrimination and violence under circumstances of rapid social change in Eastern Africa. The chapter covers the perceptions and practices related to wealth and power-seeking behaviors among individuals who cause harm to albinos; develops understandings of the use of supernatural power and occultism in resource access and acquisition; racial characterization as a catalyst of violence; global economic conditions that influence disparities in societies; gaps in legal frameworks to deal with crimes that have witchcrafts motivations; inadequate locally managed security systems to prevent violence against vulnerable groups; and gaps in monitoring activities undertaken by different groups of people who claim to be healers.

Chapter eight describes the changes in the natural environment and how these changes influence traditional healers’ behaviors, including migration, their ability to access medicinal flora and fauna, their ability to practice medicine, and their interactions with their clients. Emerging environmental changes are reflected in the transformation of social structure and human interactions with the environment. Traditional healers see patients on a daily basis. They interact with ritual spaces and forests when looking for medicinal resources. Therefore, healers are well-positioned to observe and articulate the effect of ongoing environmental changes on medical practices and definitions of health,

as well as healing. Mwanza has experienced varied climatic conditions between 1950 and 2005 with the average temperature increasing by one degree centigrade (LVBC). These new climatic conditions have significantly altered the response and adaptation of vectors for infectious disease (Grifo and Rosenthal, 1997), and also reconfiguring the geographical space of traditional healing practitioners. Likewise national and international environmental policies/conservation programs and interventions intentionally or unintentionally contribute to the mobility of healers, and reduce healers' abilities to practice medicine. Healers in Mwanza are increasingly obliged to alter their processes in response to changing environmental change and governance. For instance, some areas that were freely accessed in the past are now privately owned, limiting healers' access to ritual places and medicinal plant resources. Conservation programs such as the establishment of national parks though beneficial to biodiversity protection, are linked to conflicts due to deprivation of subsistence livelihood for communities in the neighborhood.

Chapter nine summarizes the transformation of traditional healing practices. My work shows that healers operating in urban centers use signs showing the specific diseases they treat, alongside costs for different remedies. Healers operating in rural areas, on the other hand, rely on word-of-mouth from clients, and are more likely to make use of ritual objects and spaces. I argue, therefore, that just as biomedical interventions frame their incursions in more social terms, so too traditional therapies are increasingly commoditized, packaged, and marketed as “products” rather than “processes,” consequently lacking their comprehensiveness and the traditionally acknowledged social networks.

PART I
POLITICAL HISTORIES OF HEALING PRACTICES

CHAPTER 2
TOPOGRAPHIES OF TRADITIONAL HEALING IN
MWANZA, TANZANIA

Natoa rai (I am requesting) that when I am dead they should bring Father Mabula and Father Sandu (Priests) so that my burial ceremony will be blessed for me to be received with honor in heaven by *Bikira Maria* (the Blessed Virgin Mary). My burial ceremony will incorporate both traditional and Christian rituals. I am telling you, when I am dead my children should call these educated people to come and bury me.”²

The epigraph above, taken from a recording made during participant-observation of collective rituals performed by traditional healers in Mwanza in 2009, illustrates a central paradox about Sukuma people that has inspired and motivated this research. They are prone to revere ritual and tradition, yet they are constantly adapting, expanding and redefining it. They inspired one of the richest colonial literatures on ritual anywhere and prompted missionaries and other “educated people,” early in their introduction, to found museums dedicated to Sukuma cultural practice. The Sukuma people have always fit uneasily and yet productively within the Tanzanian state. They have a central place in regional migrations and in the making of cultural and economic meaning in the Lake

² Interview, Mubi Makemo, Kanyerere- Misungwi, September 3, 2009

Victoria area. This chapter considers the history of the Sukuma people in that region and introduces some specifics of traditional healing as it links to broader political and social leadership in Sukuma worlds.

SUKUMA PEOPLE AND TRADITIONAL HEALERS IN MWANZA

The Sukuma ethnic group, with more than six million people, is the largest ethnic group in Tanzania. The Sukuma belong to the Bantu group who migrated from the area south of Lake Chad some 4000 to 5000 years ago, through the Congo River basin and across Lake Tanganyika before settling on the southern end of Lake Victoria (Madulu, 1998). The Nyamwezi (an ethnic group closely related to Sukuma and dominant in Tabora and part of Shinyanga regions) used the name *sukuma*, or “the people of the north,” to refer to those living in the Northwestern area of the Lake Victoria. Sukuma people call themselves *Nyamwezi dakama*, or “people of the South,” in the Sukuma language (Welch, 1974:61).

Sukuma people dominate the regions of Mwanza, Shinyanga and Tabora, even though the majority lives in Mwanza. The population in Sukumaland is scattered among both rural and urban areas. Most people live close to bodies of water and roadsides (Flynn, 2001). They depend on livestock keeping, farming and fishing for their livelihood. Sukuma culture is characterized by songs and dances performed during ritual ceremonies for childbirth, death and work (Mirambo, 2004). This historical precedent for ritual-sharing links their politically polycentric and socially diverse communities and creates a Sukuma identity over time and place, despite the key roles that migration and social change have played in this territory. Such practices, perhaps particularly the highly

mediatized contests between particular leader-healers, remain a key to a dynamic type of social peace in agitated times (Stroeken, 2001).

The learning process in Sukumaland has also changed due to political, social, and cultural transformation. In the past, sons, grandsons, parents and grandparents convened before *shikome* (a site outside the house with an open fire where male family members met). This was a place where culture, tales, riddles and legends were told. The gathering was usually held during the night as a relaxation mechanism after a day's work.³ Plans for the next day's work were also disseminated during these meetings. Sukuma cultural values were shared among older and young generations during these evening gatherings. In modern Sukuma society, however, this cultural system is disappearing due to new and widely propagated forms of education, modernization and the globalization.

Over the years, the Sukuma people have inherited and maintained taboos and beliefs that differentiated them from other ethnic groups. In the current era of globalization, the voice of the healer in the epigraph to this chapter is emblematic. During his public performance before a large crowd, he explained the way in which his father, who had also been a healer, was traditionally buried, and insisted that he preferred to be buried the same way. He noted, "My relatives will put my *fimbo ya uganga* (healing bat), traditional drum, and stool made of *mkola* plant (*Afzelia quanzensis*) in my grave, when I am dead." Many Sukuma people I interviewed noted that this practice is still generally done to *Manju* (a term designating an influential villager-diviner who is also a song composer and a leader of a Sukuma dancing group).

³ Interview, Pasori Maga, Kisesa-Mwanza, August 8, 2006

Although the healer emphasized the need to sustain the traditional values he had inherited from his grandparents, he responded to changes that have taken place in society by becoming a follower of Christianity. Many people in the country adopted this same practice. The healer seemed to suggest that there is no conflict between tradition and Christianity, emphasizing that he preferred to have a Priest pray during his burial ceremony. This healer's vision is more syncretic than some of his peers in the healing community. Another interviewed healer noted, "People have ignored the taboos; they are eating foods that were prohibited without giving consideration. But in the past it was not easy to chase stuff and start eating without knowing their source. God is not happy with what people are doing now and the devastating effects of HIV/AIDS epidemics is the result ignoring traditions." This healer also emphasized some of the taboos for some sects in the region, He recalled what people did in the past:

There are *Watemi Bakwimba* (Bakwimba Chiefdoms), people coming from Kwimba area and there are Wagolo coming from Magu area. I am a Nkwimba that I am coming from Kwimba area or Busumabu. I have also inherited Wagolo values. I am from the clan that has people coming from Bakwimba as well as Wagolo. Some taboos restricted us eating meat from cows without horns and this took place in Bulima area for Wagolo. We were told if you eat meat from cows without horns it was *mkosi mkubwa* (a curse) and no one dared to break the taboo. We were told about all these things while seated on *shikome*. People do not care anymore about these taboos and they are eating even those things were restricted in the past, that why diseases have increased and troubling many people.⁴

These various voices from within today's healing community represent a range of perspectives, some more conservative, some more progressive and integrative. These differences among healers point to the difficulty of characterizing them as a single

⁴ Interview, Mubi Makemo, Kanyerere- Misungwi, September 3, 2009

community. However, they share common important historical and cultural legacies of leadership, as well as crucial vulnerabilities to contemporary change.

Historically, the Sukuma engaged in agro-pastoralism and owned large cattle herds. Food self-sufficiency is an important indicator of material wealth and prosperity among the Wasukuma. Traditionally, as Madulu (1998) notes, Sukuma investment was directed at livestock keeping and farming, sources of pride and prestige. Previously, Sukuma participated in agricultural activities by establishing organized, communal, neighborhood support groups famously known as *malika*. Group members participated in farm activities and other societal obligations. Madulu (1998) notes that neighborhood groups were led by elected youth (*basumba batale*) who were mandated to organize and supervise mutual help, agricultural works and social activities.

Traditionally, in- and out-migration is common among Sukuma people, as their way to respond to land use and land cover changes. People tend to move from areas of high population density to areas with less density (Madulu 1998). Given that Sukuma agriculture is both land extensive and labor intensive, local neighborhood groups remain an important institution for sharing labor in farming-related activities. The major factors that have forced migration include the search for new farmland, better pasture and water for their livestock, and related economic opportunities.

The intensifying extractive industries in the region are further changing demographic conditions, creating heterogeneous societies with population pockets created by large capital investments and technologies. The migration of males to mining sites is one example. Mining sites in Geita and Mabuki host many young people from Mwanza and other regions of Tanzania. In the past, parents had strong authority. With

these changes in migration patterns, over the years the traditional family structure has changed. Younger members of a family migrate to work in mobile trades rather than remain with their families to farm in rural areas. Madulu (1998) notes that agriculture in Sukumaland has been affected by many conditions: land scarcity, increasing aridity, lack of agriculture tools and inputs, high prices of inputs, crops bought on credit, loss of soil fertility, unpredictable weather and crumbling productive infrastructure. These push factors have contributed to decisions among some Sukuma people to abandon farming to work in industries or other jobs in cities. Even with these changes, healers have responded and adapted traditional medicines; yet, healers have maintained contact with historical precedents.

HISTORICAL CONTEXT OF TRADITIONAL MEDICINE IN TANZANIA

Traditional medicine not only has healing properties, it is also critical to the social, political and economic fabric of Mwanza. Traditional medicine embodies identity and cultural values among the Wasukuma. The position of traditional medicine during the pre-colonial and colonial periods has been discussed extensively in previous literature (Cory, 1954; Tanner 1956; 1970; Feierman, 1990; Feierman and Janzen 1992). Other literature has emerged that covers a wide range of topics related to traditional medicine in post-independent Tanzania (Langwick, 2011; Stroeken, 2010; Marsland, 2007).

Due in part to colonial and postcolonial partnerships, such as those that existed between Danish scholars and missionaries and the Wasukuma, many monographs and museums exist that document or even glorify Wasukuma healing (Cory, 1949; Tanner (1956; 1958), Wiljsen and Tanner (2002; 2006), Bassire (2000), Hinkkanen, (2009), and

Stroken, (2010)). Some of this literature discusses aspects of culture and Sukuma traditional healing. Bassire (2000) notes that the objects inherited by Sukuma rulers, medical practitioners and dance society leaders have witnessed several generations of change from German (1888-1918) to British (1918-1961) colonialisms. Tanzania attained its independence in 1961 and underwent different political systems, starting with socialism in the early 1960s to the mid-1980s, when capitalism took control. These transitions have defined societies in many different ways. One of the changes has been the way in which medical practices have responded to political changes.

Since the colonial period, countries in Sub-Saharan Africa have been subjected to both exogenous and endogenous factors that have shaped the structure and landscape of medical practices. Sukuma healing has suffered immensely from the politics and development programs of both colonial and independent governments. More often than not, healers were excluded, marginalized, denigrated, feared, and despised. Government authorities said their medicine lacked standards (Stangeland et al., 2008; Feiermen and Janzen, 1992; Langwick 2010; Wijssen and Tanner, 2002). However, the region is now experiencing new forms of intercultural and cross-cultural medical systems that have gained popularity over the years. Societal ruptures, such as epidemiological transitions, also determine the consumption of traditional medicine. The transformative process of traditional medicine is featured in different literatures.

Bessire (2002), in her dissertation, *Negotiating Cultural Icons: Sukuma Art, History and Colonial Encounter in Tanzania*, used the portrayal of Sukuma art to examine how people negotiate, navigate and construct the meaning of events, such as defining the relationship of the present to the past (pp. 1-2). Turshen (1984) maps the

political ecology of diseases in Tanzania by discussing the spatial features of diseases. Hsu (2002) traces the evolution and uses of Chinese medicine in Tanzania since its independence in the early 1960s. The context and approaches used in all these literatures help to define the way in which health conditions interact with medical interventions.

Gunderson (2010), in his work, *Sukuma Labor Songs from Western Tanzania: We never Sleep, We Dream of Farming*, captured the oratory of Sukuma people, healers, and leaders of dancing groups. Through oratory and song, Gunderson analyzed the major ruptures in the pre-colonial, colonial and postcolonial periods that were observed in Sukumaland using narratives from local songs and stories. Sukuma songs portray events in economics, politics, and culture in Tanzania and are composed of some individuals that, apart from being leaders of Sukuma dancing groups, are healers. Some songs characterize the perceptions of Ujamaa villages (p.354-394), and others show the use of traditional medicine to combat crimes through Sungusungu vigilante groups in the early 1980s (p.435-452).

The work by Gunderson indicates that the role of oral poetry cannot be underestimated. Songs and dances commemorate and convey understanding and remembrance of many of the society's ideals, values, practices, and ideologies. Askew (2002) captures Tanzanian's history of nation-building using the ethnography of musical genres of coastal Swahili society including *dansi*, *ngoma*, and *taarab*. In this work, Askew shows how the chronological events are portrayed in daily-lived experiences and captured in narratives of musical performance that describe and reflect attempts by the nation to define its identity (p.285).

For Sukuma people, oral narratives fall into two main categories: real and imaginary (Mirambo, 2004). According to Mirambo, “real narratives” capture and portray actual events in temporal and spatial settings such as epidemics, wars, and natural disasters. “Imaginary narratives” present tales about the power of individuals, such as leaders of the dancing groups. However, both real and fictional narratives represent historical events, such as war, famine, disease, and geography, and they communicate messages regarding the society, the environment and behaviors.

“Reverse anthropology” is a method to study changes happening in a society by using narratives of a particular group (Kirsch, 2006). Kirsch used this approach in his project, *Indigenous Analysis and Environmental Relations in New Guinea*. Kirsch explored the knowledge possessed by tribal groups in order to explain macro-conditions through micro-conditions in a society. He recalled how tribal people in the lowlands of Papua New Guinea developed knowledge that enabled them to understand the stress caused by the invasion of transnational extractive corporations involved in mining industries.

Others have used a different approach to examine socioeconomic changes and their implications on social transformation. For instance, McGee (2008) examined the relationship between Structural Adjustment Programs (SAPs) and political development. McGee argued that the removal of government support structures forced groups to compete for resources under conditions of scarcity, even though Tanzania had historically enjoyed ethnic cohesion and stability (McGee, 2008). Hirschler (2004) traced violent conflicts by examining the transition from Ujamaa-socialism to a free-market-system, as well as the move from a one-party to a multi-party system. In examining this

transformation, he noted that the exclusion of people from political and economic processes tended to influence violent behaviors. These behaviors are further exacerbated by poor responses from government organs.

REFLECTIONS ON CONTEMPORARY HEALING PRACTICES

The presence or advertisement of traditional medicine is obvious to any individual visiting either urban or rural Mwanza. Shops sell traditional medicine. People showcase their medicine on tables, and clinics with large signboards advertise varieties of therapies. In rural areas, healers can be identified by the structure of their houses and the built environment on their premises. The most important indicator is the presence of ancestral shrines.

There are different groups of healers in Africa, each with a specific role. They may be categorized as diviners, herbalists, midwives, or circumcisers, while others are identified with combined roles (Nelms and Gorski 2006). I categorize healers in Mwanza in many different ways that reflects the language of my informants. Their identifications primarily include diviners vs. herbalists, pagans vs. Christian or Islamic healers. Healers are also identified by their places of operation, and by their interactions with others in traditional or biomedical therapeutic fields. This chapter examines processes of healing in Mwanza. It explores the different groups of healers, their methods of learning to practice medicine, the population of people consuming traditional medicine, and the competing groups of healers operating in Mwanza. The existence and survival of various medical practices in Mwanza is characterized by human needs that are influenced by health, security and economic concerns.

Both traditional and Western medicines are used in Tanzania. Traditional medicines are differentiated from western medicine by their concepts regarding the causes of illness, and by their approaches to healing (Gessler, Msuya et al. 1995). Debate about the difference between traditional and biomedical practices has persisted for many years (Langwick, 2011; Hunt, 1989; Feierman, 1985; Maher, 1999; Young, 1982). However, trends show convergence in some aspects, such as healers referring their clients to biomedical units for testing, and healers using biomedical equipment and combining therapies.

Illnesses in African culture are sometimes ascribed to supernatural forces arising from angered ancestral spirits, evil spirits or the effect of witchcraft (Gessler, Msuya et al. 1995; Nelms and Gorski 2006; Mapunda 2011). As is the case with other indigenous groups in the world, traditional medicine is closely attached to people's culture and their beliefs concerning the land and its flora and fauna (Devanesen and Maher 2003). Traditional medical practices are usually characterized by a healer's personal involvement, and by secrecy and reward systems (van den Geest 1997). In contrast, biomedicines are curative and organ-directed. Biomedicines show causative agents of diseases, and the way in which diseases occurred. Traditionally, Africans understand sickness as a complex interaction of physiological, psychosocial and spiritual factors (Busia 2005). Thus, the curative approach must account for multidimensional probable causal agents. In contrast to Western medicine, based upon the biomedical model, traditional African medicine takes a holistic approach that brings social issues into consideration as the causes of diseases, issues such social change and social conflict (Janes, 1999). Disease, good health, success, or failure are believed to be the products of

the actions of individuals and ancestral spirits, according to the balance or imbalance between the individual and the social environment (Busia 2005). My fieldwork indicates that maintaining good health for the Sukuma people involves the provision of therapies for physiological and economic security and conditions.

Increasingly, traditional healers are adapting ideologies and practices that can accommodate a changing population with modern and western ideals. Other traditions, such as Sukuma dances, have also begun to embody western values and ideas. The use of western apparel in Sukuma traditional dancing demonstrates how people are responding to the intensified presence of Western values and ideals in local cultures (Figure 3). Local practitioners have responded and adapted to the changes in a globalized



Figure 3: Sukuma traditional dancers embracing Western cultural values.

world where clients embrace traditional and Western cultures (Schumacher, 2007).

The overburdened medical facilities in Tanzania have forced many people to interact with healers as an alternative to western health and medical care. In addition, the increase in costs, created by structural adjustment policies and programs introduced by the World Bank and the International Monetary Fund in the 1980s, has been associated with an increase in people who opt for traditional medicine (Lugalla 1997).

Because of the increased popularity of traditional healing, it is a growing business in Tanzania. The experience in Mwanza shows that people visit traditional healers for medical assistance just as they would a clinic. More often, patients have to wait to be

seen. There are processes one typically follows. The response from one Sukuma healer in Mwanza indicated that if you sought treatment for a woman, you brought a she-goat; if you sought treatment for a male, you brought a he-goat.⁵ In other words, traditional medicine is a regulated procedure, comparable to the process you would follow at a *zahanati* (dispensary).

Another reason for the increased demand for traditional medicine is the rise of incurable diseases. The migration of people to urban centers has coincided with an increase in STDs and HIV/AIDS. Changing environments have created changing medical challenges. Healers recognized this situation and responded to these dynamics through mobility, discourse and practices. Their varied responses to multiple challenges in the region mark traditional healers as participants in a transforming industry. Traditional healing has evolved from a practice highly centered on healer and client networking to one that is commoditized, with less emphasis on the relationship between healer and clients. However, despite increased demand for traditional medicines, healers are vulnerable to political and environmental changes covered in detail in other chapters.

Many communities experience tensions between traditional medicine and biomedicine. The practitioners in biomedicine are worried about the ways in which traditional medicines are collected, processed, stored and administered, thus raising questions about efficacy, dosages, quality, safety, and hygiene (de Boer, Kool et al. 2005; Moshi, Kagashe et al. 2005). Healers, on the other hand, feel denigrated and disparaged by biomedical officials' criticisms. The tension between the two fields has retarded the

⁵ Interview, Mubi Makemo, Kanyerere-Misungwi September 3, 2009.

development of traditional medicine. Nevertheless, studies have shown that, despite existing tension between alternative medical practices and biomedicine, the society has agreed that “complementary and alternative medicine” will continue to co-exist and operate by complimenting one another (Janes, 1999). The coexistence of both systems may be attributed to a variety of conditions, such as the emergence of the incurable diseases, cultural beliefs, trust, and the advertisements for both systems.

One healer I interviewed introduced me to a client who had travelled all the way from Dar es Salaam to Misungwi Mwanza for a persistent urinary tract discharge.⁶ The patient’s story explains how a patient, particularly one with chronic conditions, alternates between therapies:

I have lived in Dar es Salaam for many years though I was born in Mwanza, and in the early 2009 I started seeing discharges from my private parts. I went to one hospital and I met one Medical doctor who recommended that was normal. The medical doctor recommended that I practice sexual activities regularly. He thought also that I had been infected with sexually transmitted disease, and I was prescribed with medicine to treat STDs.

Symptoms persisted despite medication I had received. I was recommended that I consult gynecologists, and they undertook “culture sensitivity analysis.” (Picked sample of my discharge and left it to grow in order to determine kind of infection I had). The medical doctors indicated that I was not infected with STDS; rather their test showed I had *candida albicana*.

I was given medicine to use for six months that each month I had to take 2 tablets three times a day for three days. I had to repeat the process for six months, but the problem persisted. I consulted another doctor who saw the same problem and he recommended also that I continue with the prescribed medicine I was given. I felt I was not getting any relief despite spending a huge amount of money for the treatment I remember paying TSH. 30,000 as a consultation fee; cultural and sensitivity testing TSH. 15,000; purchasing equipment TSH. 25,000. Seeing the doctor about the result I had to pay TSH. 30,000. The cost for the medicine was about TSH. 40,000 each time when I was advised to get medication.

⁶ Interview, Arony Bukebe, Bukerebe,-Kisesa, Mwanza, October 4, 2009

I was worried; my close friends and relatives started thinking that I was bewitched. Personally, I was not worried about HIV/AIDS infection because I had taken many tests at different places and all the tests showed I was not infected. I was even tested at a referral hospital in Dar es Salaam and all the result showed I was not infected. However, both my stool and urine showed that I had Candida Albcanus.

This conditions trouble me and I had a friend in Mwanza who introduced me to a traditional healer residing in Mbarika, Misungwi (about four-hour from Mwanza City). The next day I was diagnosed for treatment. The healer used a small piece of a wooden stick for diagnosis. The pieces are wetted by water and I was asked to spit on it. The healers discovered that I had sores in my genital part that was the cause of the problem of the discharge I was experiencing. I was given medicine and I am comfortable that I feel I am cured after using the medication for a week.⁷

About 80 percent of the population in Africa relies on traditional medicine as their primary health care (Bodeker and Kronenberg 2002; Alves and Rosa 2005; Busmann and Sharon 2006). Many

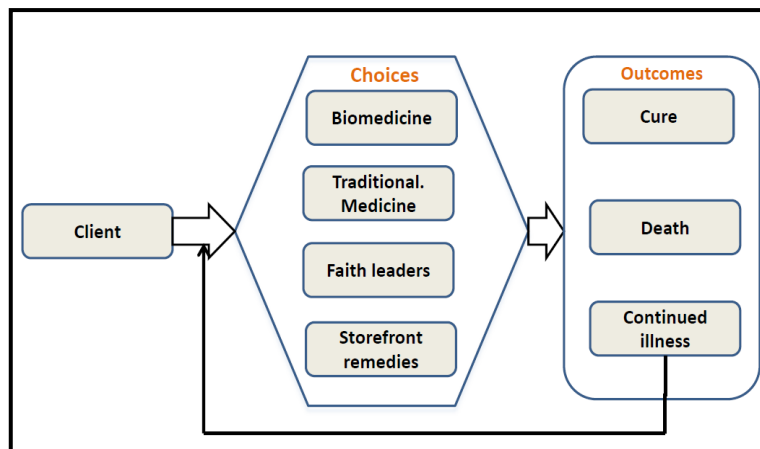


Figure 4: Healing options and outcomes in Mwanza

countries in Africa have more traditional healers than medical doctors. In Tanzania, there are conflicting figures to gauge the number of traditional healers. Menda (2003) and Mhame (2000) both suggest that there are more than 75,000 traditional healers, whereas Rukangira (2004) suggests that there are between 30,000 and 40,000 traditional healers compared to only 600 medical doctors. According to Rukangira, there is a traditional

⁷ Interview, Karekana Enalenga, Misungwi October 6, 2009

healer-to-patient ratio of 1:400, compared to a ratio of 1:20,000 for western medical practitioner-to-patient. These ratios suggest that people are more likely to contact healers than medical doctors. The Tanzanian online newspaper *Mwananchi* reported that the WHO recommends one medical doctor for every 10,000 people in Tanzania. The current ratio is 1:28,000,⁸ almost thrice as much. Stangeland et al. (2008) relate different figures. This group found a traditional healer-to-patient ratio of 1:350-450, compared to a ratio of 1:33,000 for western medical practitioners-to-patient. Regionally, the ratio may vary, depending on the number of healers available. The discrepancies concerning the number of healers operating in Tanzania is mainly due to the lack of a mechanism to determine the number of people who practice traditional medicine. In 2006, the Tanzanian government initiated a project to register all healers and to note the conditions they treated.

The attempt to register healers could have helped to identify different groups of healers, the places they operated, and conditions they treated. However, the exercise was temporarily abandoned in 2009, following the association of healers with violence against albinos (See Chapter Seven for more details). Despite restrictions by the government, many people continued to consult healers for medical needs. In Mwanza, seekers of health care services, as in other societies, opt for medical care to attend to illnesses caused by infections, consumption of harmful products, stress, old age, and injuries, as well as treatment for sorcery, neglect and violation of ancestral rituals (Maher 1999). This variety of conditions would push clients to seek sequential, compartmental, and

⁸ Source: *Moi yafunga huduma za kliniki* (Moi Ward at Muhimbili Referral Hospital Suspends Offering Services (*Mwananchi*, Tuesday, January 31, 2012)

concurrent health care services in traditional medicine, biomedicine, and faith/spiritual medicines.

SUKUMA HEALERS AND OTHERS IN SUKUMALAND/MWANZA

Any individual involved with medicine is called *mganga*. The name, *Buganga*, in Sukumaland, has been used interchangeably with other names such as *Bugota*, *Miti*, and *Makula*. However, *buganga* (medicine) is a term that encompasses a wide range of products and practices, including products for cure, poison, ritual, *samba* (attractive medicine), *salala* (repellent medicine or medicine to dislike), sorcery, *wija* (medicine making one invisible/ unseen) and *ubona* (medicine giving ability to see invisibles).

Within the Sukuma pastoralist history and agrarian society, healers were the mediators of the environment, security, and health. They also participated in activities that brought joy and reward to society. The literature has covered a great deal of Sukuma traditional medicine and their actors. Fieldwork in Mwanza reveals that Sukuma healers have long played an important role in Mwanza. These healers practice herbal healing and divination rituals that stem from historical, cultural, and ecological adaptations; they also maintain interactions with other healers from various ethnic groups. Healers combine knowledge of local flora and fauna and Sukuma ancestral beliefs with experience to make medicines for herbal remedies, amulets, and long term care (Wijsen and Tanner 2002; Mirambo 2004). These practices aim to treat people's illnesses and respond to societal challenges. However, the social structure that contained healers is changing due to the influx of diverse groups into the region. In recent years, Sukuma living conditions have changed dramatically as a result of both naturally occurring and human-driven change.

Sukuma people exhibit a wide range of health and medical beliefs that are widely linked to social, economic, cultural, and environmental conditions. The selection of traditional medicine is directly and indirectly linked to political and economic conditions and that are largely determined by the globalization processes. Sukuma traditional healing involves the use of material (plants, animal parts and minerals), rituals, and soothing songs. Two groups are involved in the use of traditional medicine: lay people who prescribe based upon experience and specialist healers who prescribe based upon their area of knowledge. As in other communities, this work includes providing spiritual and social support, determining the cause of illness and problems, and providing both preventive and curative medicines for manmade and naturally induced diseases (Maher, 1999)

Evolution and expansion of traditional medicine in Sukumaland

Traditional medicine is produced from a culture characterized by ecological adaptation, is translated using native language and is sometimes advertised in competition with Sukuma dancing groups. Some interviewed healers noted that the expansion and contemporary use of Sukuma medicine is intractably linked to the two dancing societies, Bagalu and Bagika. These two major institutions in Sukumaland have struggled for power by continuously seeking strong medicine to outwit one another in various ways, including dance performance. Historically, medical precedents in Sukumaland are memorized and retold through the Sukuma songs and poetry that have become a symbol of identity in the region. These two groups advertised the strength of their medicine by winning competitions. In other words, the culture of competition

became a driver for the spread of different kinds of medicine (medicine to attract and medicine to repel) in the region.

The literature affirms that *Sukuma Buganga* (Sukuma traditional medicines) evolved and expanded from what was considered medicine originating from Gumha, the founder of the Bagalu Dance Society, and Ngika, the founder of the Bagika Dance Society. Both of these traditional doctors received much of their training from other traditional doctors, such as Ng'home, who resided outside Usukuma near the turn of Nineteenth century.⁹

Healers among these groups sought ways to determine the efficiency and efficacy of the medicine they owned for different purposes. Likewise, these groups were keen to know the power of their rivals' medicine, invoking the adage: "knowledge is power." While each group sought powerful medicine, they also created sports and games to advertise their medicine and to seek popularity. Culturally, in order to win, they continually expanded their knowledge base by consulting other practitioners of medicine. They consulted diviners' (*bafumu* (plural) / *mfumu* (singular) advice and guidance about the strength of their medicine.¹⁰ Healers noted that this competition led groups to seek medicine from different sources to become competitive and feared. Consequently competing dance groups solicited and acquired different kinds of medicine, such as energizing and motivating medicine, *samba* (attractive medicine), *salala* (medicine to dislike), harming medicine, and medicine that could render opponents less effective. These kinds of medicine have been applied to other fields, including politics and modern

⁹ Mark H.C. Bessire –Sukuma Traditional Medicine in Notes -97).

¹⁰ Interview, Mzee Adamuka, Mwanza Town, June 27, 2010.

sports such as soccer. An athlete interviewed noted that soccer involves the application of traditional medicine to win.¹¹ More often, these medicines are applied to motivate the team and discourage the other team.

Traditional dance groups represented an important part of the social structure. Though they competed, they also promoted social cohesion between communities. The *Bagalu* and *Bagika* have traditionally held ritual dance competitions during harvest time (Figure 5). Sukuma people have aligned themselves with one or the other dancing group.

Interviewed healers in Mwanza indicated that the use of various forms of medicine has evolved from medicine used by these two groups.

People in communities gather to enjoy dance group leaders. *Manju*¹² and *Balingi*¹³ praise their ancestors and leaders

or demonstrate the strength of their medicinal knowledge. Spectators respond to patronizing songs that humiliate opponents, lazy people, and people practicing witchcraft. However, these competitions are now rare due to the political, cultural, and economic changes in the region. Ethnographic work in the region has captured sporadic



Figure 5: Performers of the Bagalu and Bagika dancing groups

¹¹ Interview, Ng'wana Ng'wanzalima, Kisesa; July 8, 2009

¹² *Manju* represents an influential villager-diviner who is also a song composer and a leader of a Sukuma dancing group

¹³ *Balingi* represents song composers and leaders of dancing group

competitions between these two groups, even though the intensity dances and use of medicine has declined. For these events to occur, they have to have financial sponsors. Recently, these events have even reflected and responded to the integration of global culture (Figure 3). Yet, despite the infrequency of the competitions, the use of medicine to win and attract crowds is still used in contemporary settings. A respondent in Matare, Misungwi, who is also a song composer known as *ningi* (a songs' composer and a leader of dancing group) noted, "I have different kinds of medicine including medicine to treat diseases. I also have *samba* (attractive, medicine to like) to attract crowds when performing dances in order to win. I have also *salala* (repellent, medicine to dislike), to neutralize my opponents when competing so that their performance will not attract crowds."¹⁴

The use of medicine among healers and *balingi* is captured in a song by a healer participating in a competition during Bulabo, in Mwanza. The song, below, explains the dynamics and relationship between Sukuma dancing groups and traditional medicine. It shows that singing talent can be enhanced by medicine. It also states that traditional therapies are beneficial to women to improve their fertility.¹⁵

¹⁴ Interview, Jomayo Mayoma, Mbarika Misungwi October 10, 2009

¹⁵ Interview and Song, Nhumbu Bumila, Kisesa-Magu, June 17, 2007

Swahili translation	English translation
Nimechoka kuwa Manju	<i>I am tired of being Manju,</i>
Sasa nifuate kazi ya Uganga niwe nawapa dawa akina mama wapate watoto	<i>and now I prefer being a healer to give medicine to women that they reproduce</i>
Hili ndilo ninalo hitaji kulishugulikia.	<i>That is what I should be doing.</i>
Nimekuwa Ngh'inda Ng'wana Makaji	<i>I have become Nghinda Ng'wana Makaanji</i>
Nimeamua kuacha utalamu kwani jambo hili lina nikosesha raha	<i>I have decided to relinquish my expertise because this issue is troubling me</i>
Nakumbuka mwaka mmoja jambo hili lilinija likasababisha nikose kabisa nyimbo za kuimba	<i>I remember in the past this thing popped-up and affected my ability to compose songs, I couldn't have songs to sing.</i>
Nikawa nafikiri je kazi yangu ya umanju nimwachie nani sasa	<i>I was wondering to whom I should pass my duties of Manju.</i>
Lakini nikwa katika hali hiyo basi nikapata jibu	<i>Who should take care, I was in that situation wondering, but I got the answer in that situation.</i>
Nikawa nimechanjwa dawa tena za kuniwezesha kupata nguvu mpya ya kuanza upya na kuendeleza kazi yangu	<i>I was incised with medicine to revitalize with new vigor to proceed with my duties</i>
Kwahiyo nikawa nimechanjwa dawa zingine mpya za kutoka kwa baba yangu Idili	<i>I was also incised with new medicine with my father Idili</i>
Maana yake yeye alikuwa na watoto wengi sana	<i>Because he was having many children in medicine</i>
Maana yake nilikuwa natengeneza nyimbo akawa hazipendi sana	<i>Because initially I composed songs, but he did not like them</i>
Lakini baada ya kutengenezwa hivyo	<i>I was then incised with new medicine,</i>
Nikawa naota sana nyimbo nzuri tena mpya	<i>And after that I was able to dream many songs and they were very good and they were new.</i>
Mwaka 1978 nilijiwa saana na mizimu ya wahenga wangu	<i>In 1978 I was visited by my ancestral spirits</i>
Nikawa kidogo tu niwe mganga lakini wazazi wangu walikataa kabisa	<i>and I almost became a healer but my parents resisted,</i>
Nikatafutiwa mganga akanichanja Bulingi-Umanju mwaka 1979	<i>and they found me another healer who incised me to do perform and become Manju in 1979,</i>
Kwa kweli nikawa Manju wakutisha sana	<i>I became popular and feared Manju</i>
Nilinyeshwa sana dawa za aina ya Minengo	<i>I was given concoction medicine</i>
Lakini nikafanikiwa sana.	<i>And I was very successful.</i>

The role of songs in these two groups is more than advertisement of their medicinal products. The songs and singers are also delivering messages to the society about the challenges and transformations happening in society. To the large extent, Gunderson (2010) captured different songs that chronicled and depicted local and international events, covering themes such as politics, the economy, wars, leadership,

natural disasters, and epidemics. It is no surprise that President Kikwete was invited to be the guest of honor in a Bulabo celebration held in 2010. Historically, this celebration brought the two competing groups together. In his speech, the president praised the event, noting it taught the young generation about taboos and cultures of Tanzania in the era of technology and globalization. The president congratulated the Bagalu and Bagika dance groups for delivering and disseminating messages aimed at measures against HIV/AIDS, and the murder of the elderly and people with albinism.¹⁶

FORMS OF HEALING KNOWLEDGE AND PRACTICES

Traditional medicine not only provides benefits to the health of an individual; it also accounts for individual and societal wellbeing. It entails fighting illnesses, misfortunes, dangers, risks and disasters. The Sukuma community hosts various groups of healers. For instance, *Mfumu* (or diviners) exist in various categories including *nchembi wa ngoko* (a chicken diviner); *nfumu wa ng'hambo* (a diviner using piece of the *Nama Combretum* tree) *nfumu wa ntwe* (a diviner using intelligence); and *nfumu wa mbale* (a diviner using dice) (Welch, 1974 p.204).

¹⁶President Kikwete appraises yearly Bulabo celebration at Kisesa noting that is the best way to show the young generation about taboos and culture of Tanzania at this era of technology and globalization. In addition, President Kikwete also congratulated the competition between the two archrivals of Sukuma: *Bagalu* and *Bagika*. The president noted that the celebrations involving competing groups are beneficial when are used to advocate measure to fight against HIV/AIDS, killings of old people and people with albinism. In supporting the groups President Kikwete offered seven cows for the celebration that normally involved different groups of Sukuma such as Bagalu, Bagika and Babasana (people with twins). During the event Kikwete was introduced to the Sukuma Chiefs (*watemi*) that were guided by their chairman Chief Charles Kafipa of Bukumbi in Misungwi. Kikwete was introduced by the name given by Sukuma people Ng'humbu Banhu (A man of the people) when he visited Mwanza. Source: ***Mzawa Issue No. 560 Saturday, June 12, 2010.***

Mfumu use different paraphernalia to predict events or to describe past events. They are known to be capable of foresight. Through the knowledge of the past and present natural events, they are able to provide advice on measures to address threatening events. Diviners use different environmental resources for divination, including chicken, water, *mnyaa* (*euphorbia tirucalli* L), *solo* (a divining board), *ungo* (winnowing basket), *kioo* (mirror), *mbuzi* (goat), *ulezi* (finger millet grain) and *mtama* (sorghum grain). Historically, diviners played a big role as advisors and guides (*waongozaji*) of famous healers in societies. Likewise, political leaders, such as chiefs, relied on *mfumu* for directives that were important for their leadership. Divination does not come from secular schooling. Instead, divination derives from in-born knowledge and special talents. For this reason, *bafumu* (diviners) are rare, and each is *miujiza* (a miracle).¹⁷

The knowledge of divination in societies involves techniques of collecting, accessing, assembling and disseminating knowledge in a way that allows clients to understand past, present and future events (Thornton, 2009). Divination is used to describe and predict events, illnesses and other social problems. This power of divination has brought issues of contestation, particularly when people try to differentiate between natural and human induced illnesses and other problems in society

DIVINATION: CONTESTED DISCOURSE AND PRACTICE

Divination is a subset of healing practices used to diagnose, treat and prescribe medicines, and to otherwise find solutions to illnesses and other problems that healers encounter on a daily basis. Diviners are differentiated from other groups of healers based

¹⁷ Interview, Mzee Adamuka, Mwanza Town, June 27, 2010

upon their capacity to foretell and determine conditions afflicting people through the guidance of ancestral spirits. In this respect, they are highly specialized, or even called to that work. Kale (1995) notes people do not become diviners by their choice; instead, ancestral spirits selects them. Divination is a widespread phenomenon in Sub-Saharan Africa and has been the topic of a great deal of anthropological fascination following the pioneering work of Victor Turner (Turner 1969; 1975). Divination also gets a great deal of popular attention. Different names exist for various vernaculars. In South Africa, for instance, diviners are called *isangoma*; in Sukumaland they are called *wafumu*.

In my fieldwork in Mwanza, I interacted with both herbalists and diviners, and with some practitioners of both approaches. However, the majority of the interviewed healers, even diviners, preferred to be called *nyamiti* (herbalists), due to increasing government attention to and restrictions on traditional healing. Herbalists are healers whose main sources of therapies are dependent on the use of medicinal flora and occasional animal parts. While a majority of the healers are known as herbalists, the claim to be an herbalist has been reinforced by government restrictions on the practice of divination. Thus, healers prefer to say that they are *nyamiti* (herbalists) for reasons of personal security and to avoid interference by government agencies. For some, this is more than a superficial distinction:

You know there are two types of healers; there are those who are only herbalists, but there are also those who learn the practice of medicine by dreams; I am one of those who learned through dreams, and I conduct divination.”¹⁸ Yet others point to the intertwined nature of plant based healing practices and divination; one healer remarked “I am known here as “mfumu” (a diviner) who uses *mnyaa*

¹⁸ Interview, Sundili Eli; Nyamatala-Magu; April 8, 2010.

(*euphorbia tirucalli* L. plant) for divination. People bring their troubles and I treat them.¹⁹

If these activities are separate in theory, in practice there is a resistance to abandoning divination. Healers consider divination to be one of the core components that makes traditional medicine holistic. One interviewed healer sees divination as a diagnostic procedure. Diviners, as covered in other sections, use different paraphernalia to predict events and to identify causes and solutions to problems and illnesses. I asked another healer and *ningi* (a leader of Bagalu dancing), who wore *mnyaa* as protective medicine while competing in Sukuma dances, why *mnyaa* is so popular in the field of Sukuma traditional medicine. He noted, “Wearing that plant, I have never lost in a competition, and *mnyaa* is used in divination, and it is called *nhumbila chalo* (that it is spread everywhere). It is a plant that continues to regenerate when cut. It is plant that is capable of revealing a lot of things.” He continued to explain that *mnyaa* is used as an attractive medicine. Healers have *mnyaa* in their houses. They use the plant as fencing. They also burn and grind it to make attractive medicine to get more customers so that they can build their fame in society.²⁰

Another healer, who noted that he was able to attend a patient that was suspected to be suffering from HIV/AIDS, explained the importance of divination:

I have not tried (treating people with HIV/AIDS), but there was a client who came here; she was emaciated; the daughter of Ng’wana XX; she was married at Isawida village; she was treated there without getting any relief. She was brought here at night extremely thin and everybody believed that she was infected with HIV/AIDS. But it was not, when I divined I discovered it was not HIV, it was

¹⁹ Interview, Neche Hango, Nyamahimbi Mahaha, April 7, 2010.

²⁰ Interview, Nhumbu Bumila, Kisesa-Mwanza, July 24, 2007.

just another disease. I treated her for about a week; it did not take a long time for me to cure her, and she is in good health even today.²¹

Divination and Contestation: Several of my informants who practice divination fear increasing government restrictions on the practice. Given the history of Ujamaa measures against healers, their fear is reasonable. The government, however, claims that divination is linked to troubling and violent practices that are on the rise. One afternoon, when I visited a healer in Mwanza city, he seemed distressed. He read a letter from the regional office in Mwanza that stated healers were prohibited from divination in Mwanza city.²² A Maasai healer who showcased his medicine in Kilombero Street, in Mwanza city, lamented that healers can be restricted from incorporating all their knowledge and skills to respond to people's diseases. Divination, according to the healer, is a way for healers to diagnose diseases and offer treatment, just as medical doctors do tests to identify problems and prescribe medication. In other words, restricting divination limits healers' ability to practice medicine.

Continued divination practices among healers demonstrate the centrality of the practice to healing process. However, its use also serves as evidence that enforcement of interdictions about healing is a challenge. Orders from the state designed to restrict healers' activities related to divination are hard to implement for a variety of reasons, including the diversity and complex nature of traditional medicine and its key actors, the lack of knowledgeable personnel from the government to enforce the order, and the breadth of traditional medicine as an economic sector and social field. Healing activities

²¹ Interview, Lusalu Lute Nsago Gwa Mihayo, Minoang'ombe - Ndagalu; July 26, 2010

²² Letter read when interviewing Mzela Richa, Mwanza City; February 2, 2010.

encompass aspects of beliefs, health, security, economy, politics, and sports. In addition, there are few written records of most healers' locations or what specific practices they undertake, despite efforts by the state to register healers. A registry was introduced in 2006 but was abandoned in 2009, following a government order that all healers should stop practicing medicine. The order was a response to allegations that healers were complicit in albino killings between 2007 and 2010.²³

The controversy surrounding divination is not only between the government and healers; different groups of healers also compete for power, recognition, and fame. Maasai healers, for instance, are more likely to be herbalists, particularly those who operate in urban areas away from their place of birth. A Maasai healer with his two sons, operating in Mwanza City, challenged healers who perform divination, arguing:

We have our own system of disseminating knowledge of medicine from generation to generation. In our native lands, we know the different functions of both dried and wet medicinal plants; we distinguish between medicines that have to be ground. Diviners do not know about medicine. It is the one who collects and sells medicine that are real *waganga* (traditional healers) due to their knowledge of medicinal plants. Diviners still come to us just like other customers, to collect medicine.²⁴

We thus see that, despite the synergies between plant knowledge and the ritual and interactive knowledge needed for divination, there are also ways that the two can be seen as separate, competitive spheres in the broader, internally varied traditional healing community.

Interviewed healers noted and acknowledged that death is upon God's will. Healers, however, noted that *mashetani* (demons) are known for their evil and destructive

²³ Details covered in albinocide chapter.

²⁴ Interview, Oleluca Laze, Mwanza City; February 2, 2010.

nature. They cause harm, injuries, misfortunes and deaths to people. However, demons need mediums to accomplish their evil deeds. Through these mediums they create conditions to perpetuate their evil acts. Through demonic ideas and practices, people make hazardous materials, including poison, weapons, *uchochezi* (instigated violence), and *uchawi* (sorcery, interchangeable with witchcraft).²⁵ More often, witchcraft is performed secretly and emerges through features such as accusation and blame. Witchcraft involves beliefs and practices that employ supernatural forces as a means to achieve a goal, such as harm, bad luck, profit, injury, or fertility (Geschiere 1998, Stroken, 2010). Although invisible, the phenomenon of witchcraft persists in many societies, threatening many different aspects of life for many people (Faure, 2002). The government's dealing with witchcraft has been a contested issue. The Witchcraft Ordinance stipulates that anyone caught practicing witchcraft or possessing witchcraft materials can be charged with an offence.²⁶ Despite existing legal frameworks to deal with witchcraft, the legislation is rarely enforced.

Traditional healers assume different roles in societies, including the role of political leader. For many years, healers have been credited with influencing social cohesion (Wijzen and Tanner 2002; Mirambo 2004). Historically, political leaders relied upon traditional healers to ensure fertility for people and their agricultural activities. In recognition of the importance of rain, rainmaking rituals were performed regularly. Traditional healers who specialized as rainmakers were famously known as *bagemi bambula*. Rain was proof of the chief's political efficacy and his ability to cool the land

²⁵ Interview Mzee Adamuka, Mwanza Town, June 27, 2010

²⁶ Referring to the Witchcraft Ordinance of 1928 (Ch.18 of the Laws of Tanzania) amended in 1956.

(Sheridan 2004). In some cases, nominated chiefs either had to have knowledge of rainmaking or had to employ headsmen in their administration who had such knowledge (Welch, 1974, p. 164). Practice of these rituals has dramatically declined due to the abolishment of chieftaincy (*ntemi*) institutions in 1963, two years after Tanganyika became politically independent (Welch, 1974).

ACQUISITION, TRANSMITTANCE, AND PROTECTION OF KNOWLEDGE FOR SUKUMA HEALERS

More than eighty percent of the population in Tanzania relies on traditional medicine. The quantity and quality of traditional medicines offered is determined by the continued availability and access to medicinal flora and fauna. Different kinds of plants, large and small, terrestrial and lacustrine, constitute about 75% of traditional medicine. Animal products make up about 20%, and minerals constitute the remaining 5% (Alves and Rosa 2005). Studies indicate a decline in areas containing natural vegetation that supplies medicinal flora and fauna worldwide. This decline threatens the sustainability of traditional medicine (Cunningham 1997; Alves and Rosa 2007; Alves, Rosa et al. 2007)

Understanding the diversity of healers and their methods used to acquire medical knowledge and skills helps to explain how different groups of healers interact with the environment and the medicinal flora and fauna required in traditional therapies. These understandings are essential for collaboration among different groups of healers. Their efforts sustain the diverse medical practices among healers. Scholars of traditional healing to date have categorized the diversity of healers in terms of ‘survivalist’ and

‘growth business activities’ (Rogerson 1996). The former undertake healing practices as a way to support daily needs, whereas the latter group practices medicine to expand their economic activity, such as increasing the size of their herds or opening other income-generating activities.

However, I argue that a third group of healers offers therapies when needed, without seeking compensation. I call this group “servants of the community.” These three groups of healers interact with the natural environment and clients in many different ways. Others have categorized traditional medical experts as herbalists, diviners, bonesetters, traditional birth attendants, and others who perform multiple functions (Figure 7). In African countries with rapidly increasing urbanization, the use of medicinal plants has expanded beyond a specialist activity among healers to include an informal sector of medicinal plant gatherers (Cunningham, 1997). One Maasai healer operating in Mwanza noted that there are three groups of traditional healing practitioners: 1) diviners, 2) sellers of medicines, and 3) collectors of medicines.

Field observation and the literature indicate that there are different categories of healers who perform different functions, such as divination and herbalism (Gessler et al. 1995). Diviners are equipped with knowledge to identify illness, its causes, and possible treatment. Herbalists, on the other hand, possess herbal knowledge that is applied to treat different conditions. Healers in different societies have different roles. These include: providing spiritual and social support, diagnosing causes of illnesses, death, and other social problems, and providing preventive and curative medicine (Devanesen and Maher 2003). Studies of Sukuma healers have identified specific tasks that healers are capable of doing and different techniques they use to respond to different problems. These tasks and

techniques include divination, mind reading, protection of people, interaction with spiritual beings, retraction of objects causing illnesses, incisions, body cleansing, the use of songs to heal, and the offer of spiritual and social support.

The forms in which healers acquire their knowledge determine their practices. In Mwanza, as in other places, healers acquire medicinal knowledge and a set of systematic skills in various ways (Figure 6). Others may consider these practices informal, but for traditional healers, their formal course of study includes: 1) individual interest and

learning from other healers through apprenticeship, 2) learning through seeking or receiving therapies among clients, 3) dreams that are said to be guided

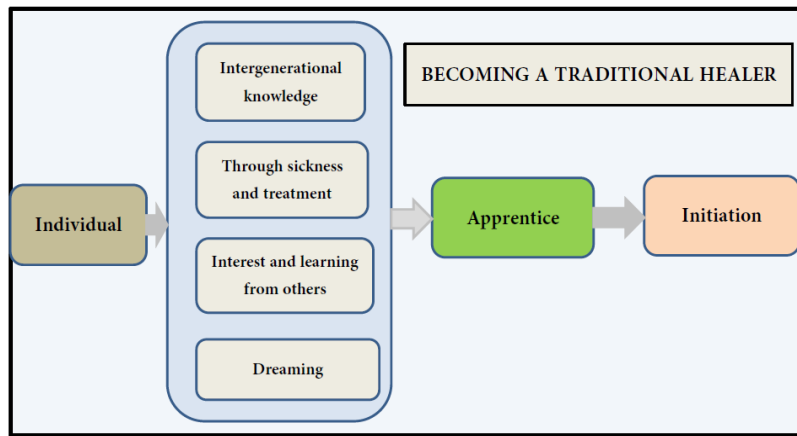


Figure 6: Learning process to practice traditional medicine

by ancestral spirits, and 4) transmission of intergenerational knowledge from parents to children or grandchildren (Gessler, et al. 1995). The learning process is not static and does not depend upon a single approach; rather, learning is a continuous and interactive process in which one method complements and connects to another.

Some of their learning experiences were captured in healers' narratives, as shown below. Some interviewed healers noted that they had to undergo intensive training, whereas others had different experiences that suggested the learning process had been sporadic. These different modes of learning and practicing medicine make it difficult to

distinguish between charlatans or quacks and genuine healers. A 58-year-old healer recounted how he began learning because of personal interest:

I was interested in learning about medicine and I went to the healer who was my father in-law. I stayed there for some weeks and I received training for more than five months. I learned about healing, protection medicine and cleansing people's star (*kusafisha nyota*) for luck (*Nilijifunza dawa za tiba, mazindiko, nyota na madawa ya kutoa ndagu*).²⁷

The above experience indicates that medicinal knowledge can be obtained through relationships with family or non-family members. Many stories from the field revealed how people transitioned from seekers of medical services to medical care providers. This process of learning while receiving therapies occurs not only among seekers of medicine and practitioners. In addition, intermediaries may act as links for treatment and knowledge transfer to facilitate the process. This learning process helps medicinal seekers identify healers who will then become their teachers in a process that is called *baba nhemba* (father of medicine). On the other hand, *bahemba* (children of medicine) indicates an apprentice who is not necessarily blood-related kin. Instead, *bahemba* is the kinship established by knowledge transfer and sharing (Hinkakanen, 2009).

Another respondent noted that knowledge acquisition might originate from seeking medical care:

I was directed by my colleague, telling me to go this way; he took me to the healer known by the name of Masai. I had an erectile dysfunction problem, but I was treated effectively by one plant known as *mkolomije/mgogondi* (*Phyllanthus engleri*), and I fully recovered. There were other medicines that were plugged in my rectum; these contained *itula itale* (*Solanum sp.*) *igeye* (*Acacia brevispica*),

²⁷ Interview, Arony Bukebe, Bukerebe Kisesa-Mwanza; October 3, 2009

and *itumbati* (*Nicotiana rustica*, or tobacco leaves). Since then I have used the same medicines to treat other people and they have been doing well.

Still, learning about medicine and acquiring knowledge to treat certain conditions does not by itself give assurance and satisfaction of competence, as the same healer pointed out. “I can’t call myself a full practitioner; rather I am just a herbalist, and I just help people.”²⁸ To be a full practitioner, he must undergo necessary training through an apprenticeship before he can be initiated as a healer (Figure 6). Herbalists spend a few years as apprentices and are less likely to profess to the possession of divine powers (Truter 2007). One healer transitioning from illness to practicing medicine explained:

I was troubled regularly; I was seriously ill in 1977. This came after I had grown up and obtained a high yield in my harvests; I was bewitched, and my whole body swelled. I went for treatment in traditional medicine and recovered at Mzee Mhangwa. I was ill in my legs and I was not able to walk, even to go to the toilet. I came back after the treatment and I entered this field of practicing medicine, and I have been doing it until today. I am known and people bring their children even at night; I treat them and they recover. This expertise is obtained from the divine and spirits of our parents (ancestors).²⁹

For the respondent above, recovery is a proof of ancestral approval and guidance and also a mechanism for giving back. He deflects the social danger of doing too well for oneself without redistributing those resources within the community by his work for others. The role of individuals in Sukuma society, especially those who possess power, is similar to that of other communities, such as the Aboriginals. Each individual has an obligation to society. A person will do well if he or she is willing to offer service to the community in need. For Aboriginals, for instance, individual well-being is always

²⁸ Interview, Maja Jame, Hinda-Lugeye Magu; May 8, 2010.

²⁹ Interview, Wang’wa Yachalo, Nyasato-Ndagalu; July 24, 2010

contingent upon effective discharge of obligations to society and the land (Devanesen and Maher 2003) quoting (Morgan et al., 1997:598)

A healer also transitioned from seeking to provide traditional medical care. In his case, he first sought biomedical care, but finally preferred the services of a traditional healer. In telling his story, he noted:

I learned about these practices after being ill from two illnesses including *kvimba mwili* (swelling of the whole body) caused by *safura* (hookworm) and headaches that was caused by eye problems. I underwent an eye surgery, but it was not helpful. I was directed by my relatives to consult a healer they knew who gave me medicines *ya kufukiza* (the process in which a patient receives medication through smoke), which helped me a lot; but later again I met with another healer who asked me to find *nyongo ya samaki* (bile from fish) called *ningu* (*Labeo victorianus*, one species of fish on the verge of disappearance in Lake Victoria).³⁰

In a situation in which medicinal flora and fauna are disappearing, healers are increasingly asking their clients to collect the material needed for their therapies, as the healer, above, noted. He continued, “I also received other treatments from other people, and from that experience I learned to treat conditions such as headaches, *kwikwi* (hiccups) and *presha* (high blood pressure). I have also learned about medicine to treat conditions such as *ngiri* (hernia) and *kichomi* (a sharp stabbing pain).”³¹

According to the healers, learning to practice medicine, particularly performing divination, is determined by what they call *wito*, a calling bestowed by ancestral spirits. Healers who acquire knowledge through this process have to rely on supernatural forces in their diagnoses and treatments (Tsey 1997). This calling is considered important because it allows the practitioner to execute medical care duties willingly,

³⁰ Interview, Masa Buba, Lugeye A- Magu, May 10, 2010

³¹ Interview, Masa Buba, Lugeye A- Magu, May 10, 2010

unconditionally and with ethics embedded in the knowledge acquired. However, practicing medicine depends on one's ability to recall uses of different medicinal plants.

As one healer noted:

You can write or keep it (knowledge about different medicine and the way they are applied) in your memory. Children are taught while growing. Our father taught everybody about medicine and almost everybody knows it, even his grandchildren; they are capable of helping people with their medical needs. But, parents know who should be trusted in a family to be given knowledge of medicine; there is always one (child) who is liked more than others, and is the one who is given everything to help others.³²

Interviewed healers also noted that the transfer of knowledge is a cyclic event; those who are trusted must disseminate the knowledge and offer services to everyone, without discrimination:

As we are doing today here (when another healer, Musobi, was initiated) we are aware that the same procedures (of disseminating medicinal knowledge to others) will be followed, and that medicine will be given to those who are not *wachoyo* (niggardly people) so that they can protect, help, and attend to people from illnesses and other threats. Therefore, one is supposed to respect everybody without discrimination, whether they are *wendawazimu* (mentally ill persons) or *wenye ukoma* (persons with leprosy), because they all belong to you (healers who are considered health care givers)! And that is an ethic of having knowledge to practice medicine.³³

Thus, healers recognize that society hosts negative aspects, such as discrimination, stereotyping, and prejudice, and that those most affected are minority groups, such as those with disabilities. A person is required to allocate a substantial amount of time and resources in order to learn to practice medicine. Competency was determined by the way in which apprentices were able to treat people. As one of the healers noted:

³² Interview, Sendose Ndole; Kanyerere-Misungwi, September 3, 2009.

³³ Interview, Sendose Ndole; Kanyerere-Misungwi; September 3, 2009.

People interested in learning about medicine were supposed to visit and stay at healers' compounds sometimes for more than ten years; in the process, people learned how to process medicine; they were assigned to go and harvest medicine and prescribe medicine to some clients. Competence was judged by the level of satisfaction from clients. After being approved by the trainer, the apprentice is able to start helping people and will be initiated to become an independent healer.³⁴

The legitimacy of healers in society is not based on academic certification, as in the biomedical field. Instead, merit is based upon the outcomes of their practices. Legitimacy is also facilitated by a healer's initiation process. Famous healers in the village attend the initiation and people in the village are invited to witness the event. In addition, an initiate healer undergoes certain rituals and is offered a variety of medicines. This community process imbues new healers with legitimacy, authority and recognition.

The process by which a healer learns to practice medicine is a form of exchange between knowledge and material things in a society. In this chapter, knowledge refers to the ability to know or to having a set of organized ideas used to fulfill certain tasks. Material refers to tangible items such as money, livestock, and grains, to mention a few. In the field of traditional medicine, seekers of medicinal knowledge have to pay by offering their labor and materials, such as cows, in exchange for knowledge they acquire. The exchange of knowledge and material things creates a balance. Healers disseminate knowledge to other groups. This knowledge gives others opportunities to establish their own social networks and to acquire status in the society through the interactions they will have with their clients (patients).

³⁴ Interview, Mubi Makemo; Kanyerere-Misungwi, September 3, 2009.

Apart from the fame attached, acquiring knowledge in medicine creates a condition to accumulate resources through payments and compensations for medical services offered. Seekers of medical knowledge have to pay for the knowledge they seek. Healers noted that these payments imitate what their predecessors did when these healers were learning about medicine. Forms of compensation varied and included money, livestock, or labor, as one of the interviewed healers noted: “When my father-in-law was satisfied that I was capable of treating people, he wanted me to pay six cows. I stopped (learning) there, he was 90 years old and he has taught his children and others *bahemba* (apprentices as children of medicine).”³⁵ Again, compensation for medicinal knowledge and skills could involve the use of one or even multiple forms of payment. Mubi, who was initiated to become a healer, revealed the substantial amount of resources he had to pay, including money and livestock. But Mubi was also confident that he would earn back his payments and more with the knowledge and skills he learned:

Until today (the day when he was initiated) I have already spent four cows. Three of them were given to *baba nhemba* (the person giving medicine) for sharing the medicinal knowledge; one cow was for food for people attending the initiation ceremony. I offered also a goat and a black sheep that were all used for ritual purposes. I have also given money to the father. It is not a normal thing rather a sacrifice and if one is prepared to learn about medicine he is supposed to be well prepared. Generally, it is an expensive business in order to accomplish this task, especially when equated to our living standards in rural areas.³⁶

When asked if the initiation exercise might be considered a loss, Musobi continued:

Frankly speaking, this exercise has cost me a lot; by examining it closely you will see I have given four cows and goats that have been used for rituals. But my expectation is to get more. I believe that the Lord will open doors for more opportunities, and I will be able to get more, because I have succeeded in

³⁵ Interview, Arony Bukebe, Kisesa-Mwanza; October 3, 2009

³⁶ Interview, Mubi Makemo; Kanyerere-Misungwi, September 3, 2009

returning our medicine home (indicating that the person he calls father of medicine is a relative and since the medicine is shared to a relative, it is then brought home).³⁷

The acceptance of the Lord as a Supreme force is no different from Christians' faith that people achieve what they want through an almighty Lord, who is the ultimate provider and enabler for those who are willing to give. Healers believe that medicinal knowledge is a blessing and strive to serve many people in order to be awarded by their Lord.

HAZARDS FOR HEALING PRACTITIONERS

The Tanzanian government recognizes that healers protect traditional knowledge from biopiracy. A manual prepared in 2007 emphasizes the need to prevent misappropriation of traditional knowledge (biopiracy), to preserve traditional practices and culture, to promote traditional knowledge and its importance in traditional medicine, to preserve medicinal plants, genetic resources and biodiversity, and to promote fair and equitable distribution of the benefits derived from technologies and innovations based on traditional medicinal knowledge.³⁸ The protection of traditional medicinal knowledge is galvanized by the way in which healers keep their records and by what information is to be given to outsiders. Stroeken notes that after staying and observing medical practices in Sukumaland, he came to realize that the knowledge given to foreigners about practices

³⁷ Interview, Mubi Makemo; Kanyerere-Misungwi, September 3, 2009.

³⁸ The Manual prepared in December 2007 on how to protect traditional medicinal knowledge in Tanzania. Accessed on November 12, 2011 from http://www.tanzaniabiodiversity.com/archivio/html/File/MANUAL%20FOR%20PATENT_FIN AL%20VERSION.pdf

and specific medicinal plants and flora and fauna was not necessarily complete or correct (2010 p.xiv). Sukuma healers have historically protected their knowledge. One of them noted:

Traditional knowledge is a treasure; we keep this knowledge in our mind, because we are able to dream about medicine when we speak to our ancestors; we meet them in our dreams and they tell us about medicine that a particular plant treats certain conditions. And, if you try it you see the result that clients have been cured. We also have books that we write to keep records about each plant and its function. Our parents and grandparents did not like writing and keeping records for fear that their records and knowledge will be stolen. It was prohibited in the past to get close and befriend healers' children that secrets and knowledge of medicine could have been passed along by tricking children.³⁹

But the danger of the theft of traditional knowledge still exists, (Kihwelo, 2005) due to people's increased levels of education. Another healer explained, "In the past, keeping this knowledge of medicine was difficult because our grandparents and our fathers were lacking necessary education to know the importance of it; that's why some medicinal knowledge is lost, since it was taken by foreigners."⁴⁰

Changes occurring in societies have made healers more aware of the ways in which knowledge can be easily extracted from traditional communities for the benefit of others. The recognition of healers as a group seems to be helping. As one responded noted, "Now we are many and we have learned; it is not easy for foreigners to take our knowledge without our consent."⁴¹

Knowledge in the field of traditional medicine can be a threat to someone's life, particularly when healers are competing for power, fame, and customers. A healer

³⁹ Interview, Mubi Makemo; Kanyerere-Misungwi, September 3, 2009.

⁴⁰ Interview, Jolema Deus, Bujora Kisesa-Mwanza, June 30, 2006.

⁴¹ Interview, Jolema Deus, Bujora Kisesa-Mwanza, June 30, 2006.

respondent remembered a fellow healer who was killed and noted that resentment and jealousy are common, particularly when healers compete for fame and power. The respondent recalled:

I also remember I had another serious problem and I was forced to go and consult another healer known as Ng'wana Kahama in Ngulyati. But, she was killed by being hit by a hammer beating in her head – they killed both her and her husband. They killed her (a healer) because of jealousy; people resented her for her popularity in medicine.⁴²

These ill feelings among healers were captured in another interview with a healer. When asked about his collaboration with other healers, this healer noted:

Generally, we healers have ill feelings/hate (*chuki*) particularly when people see one healer is receiving many customers, then other healers will not be happy and they will find means to render him incompetent in the field, not able to cure people. There are very few who could collaborate, personally when I arrived here I tried involving others that we have collaboration and have our own community/organization for healers, but that did not happen.

Now, if I wake up and decide to go to my neighbor for a help I will be asked for money. We healers we are troubled by jealousy that is why we are not collaborating. Imagine I was married and my wife was a healer and she was called Gamalu, but *tulichonganishwa* (we were made to fight), and we had to divorce, and now I have remained with one healer who we can collaborate and he is called Mbalu.⁴³

These events exemplify the perils of healing knowledge within the field. Healers have to secure their bodies, family, residential premises, farms, and livestock against human and naturally induced threats using *nk'hago* (protective medicine). Healers recognize the presence of individuals who use the profession of traditional medicine to harm people during fieldwork. Interviewed healers noted that, in the field of traditional medicines, there are good and bad people. Rather than asking who is getting a license,

⁴² Interview, Wang, wa Yachalo, Nyasato-Ndagalu; July 24, 2010.

⁴³ Interview, Maja Jame, Hinda Lugeye, August 7, 2010

healers noted, the government should ask for what purpose is the license sought. Healers were worried about individuals who are not healers who want to obtain licenses and attain legitimacy to hide their bad practices. The healers worry such individuals will defame licensed healers. One of the interviewed healers noted:

The field of traditional medicine is divided into three categories of personnel including: 1) *waganga* (healers), whose main duties are to treat people and for them they are not involved in evil acts or they are not intended to cause harm to others. This group had few people and they have many *miiko* (taboos and beliefs). 2) *wanamazingaombwe* (magicians), who possess knowledge to fool (*kupumbaza*) people. Their main target is to get money or people's property (*kupata njia kwa kitu cha urahisi*). 3) *Balogi/Wachawi* (sorcerers), who, according to the healer, are a dangerous group and host people with evil intentions. They are destructive using their dark science (*sayansi ya gizani*) to harm other people and cause misfortune to people; they are the main cause of the problems and this is the large group.⁴⁴

Another healer had a different opinion, suggesting that an individual may occupy a healing position or a sorcery position depending on the intent of use for the knowledge they have acquired (whether to heal or cause harm.) People may possess both knowledge to heal or to harm, but choices they make regarding how, or whether, to use that knowledge differentiate *balogi* (sorcerers) from *baganga* (healers). In other words, healers may have received training in dark science and it is their restraint from use that makes them good people. According to a healer named Antony, healers are trained in evil knowledge but are restrained from using it by religions that prevent people from performing actions that are harmful.⁴⁵ The presence of individuals who used their traditional medicine to cause harm has been recognized in some parts of Tanzania. The society of healers has vehemently condemned such actions. The online daily newspaper,

⁴⁴ Interview, Yusuzu Mwalilo, Butimba-Mwanza February 13, 2010

⁴⁵ Interview, Arony Bukebe,-Kisesa, Mwanza, October 4, 2009

Majira, quoted the Organization for Traditional Healers and Birth Attendants (midwives) in Kilimanjaro who warned that healers who violate rules in medical practices might be subject to legal action.⁴⁶ Such measures are aimed at controlling con men who claim to be healers in order to steal people’s money and properties.

MULTIPLE AND INTERACTING ROLES OF HEALERS IN SOCIETY

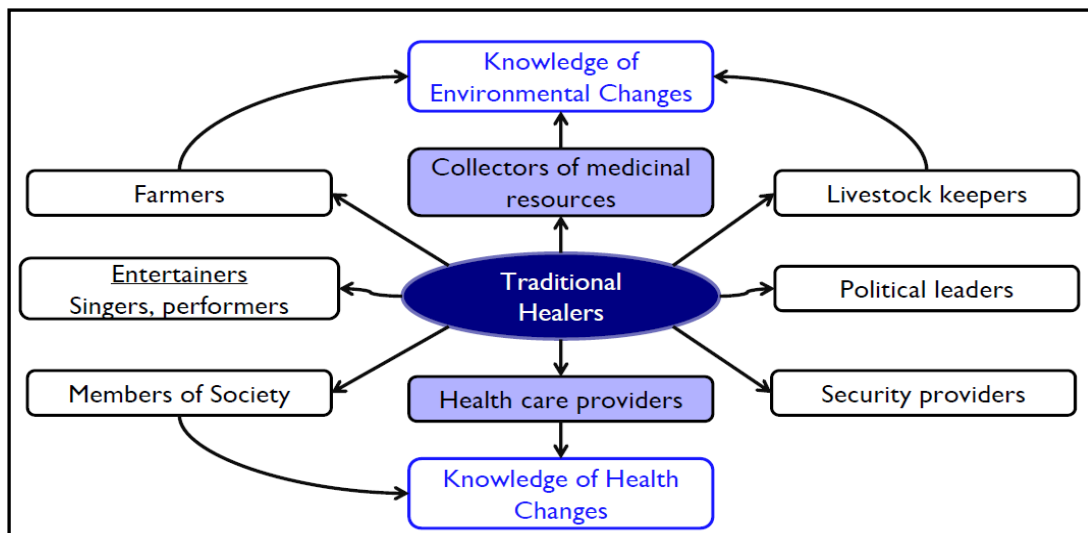


Figure 7: Multiple roles of traditional healers in society

Sukuma people see health as a concern beyond an individuals’ physical system in order to account for conditions such as economy, production, food, security, joy, happiness, fertility, social life and relations. Their understanding is similar to the

⁴⁶ *Umoja wa Waganga wa Tiba asili na wakunga wa Jadi (UWAWATI)* (The association of traditional healers and midwives) in Kilimanjaro has warned individuals who violates rules in medical practices. The organization stressed necessary measures will be taken to those who violate rules. “Mr Badi warned individuals committing crimes against people with disability and old people. (Source: *Majira*, Sunday June 6, 2010 - *Waganga wa jadi walio wachonganishi waonywa*)

definition, by the WHO⁴⁷, that health is a state of complete physical and mental wellbeing, and not merely the absence of disease or infirmity. Healers operate in an environment that is profoundly affected by disparate aspects. Two important aspects are the internationalization of biomedical care and the rapid changes in society via politics, culture, and the economy. However, healers have adjusted and adapted to changes, and they are still consulted for health and security services. Healers' roles can be divided into four categories: economic, social, ecological, and political.

1. Economic

Healers comprise a group of people who strive for financial gains to improve their livelihood and living standards using their medicinal knowledge. In order to achieve these objectives, healers complement their practices with other activities, such as farming, livestock keeping, and other informal activities. My field observation indicates that healers in urban areas are increasingly selecting a medical landscape that is accessible and reachable by many clients. In rural areas, healers will seek to secure land that is productive. The number of his clients determines a healer's fame. According to the respondents, some healers are more likely to use attractive medicine in their compounds in order to increase their number of clients. Power seeking through traditional medicine has existed in societies other than Mwanza. Mapunda (2011) explained the way in which a monopoly over iron smelting in Rukwa, Tanzania, was controlled by the use of traditional medicine. Mapunda noted that people's access to the worksite was restricted;

⁴⁷ The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of diseases or infirmity (Callahan, 1973).

they were asked to undergo ritual procedures that involved human sacrifices, nudity, or were asked to bring objects that could hardly be found, for rituals that were difficult to perform. The power struggle involved a few smelters with knowledge of traditional medicine who used this knowledge to gain a competitive edge in processing iron ore. Other iron smelters sought out traditional medicine to protect themselves against risks involved in their work.

In Mwanza, people have used traditional medicine to maintain their successful businesses. The economic role of traditional healers is captured in the song lamenting the death of a popular healer who was also a *ningi* and supplier of wealth medicine. His clients (businessmen) were devastated by his death. Grievings of the businessmen are portrayed by the song from *ng'hemba* (the son of medicine to the deceased), who also describe the large number of rich people number who attended the mourning ceremony. The popularity of the deceased helped people expand their businesses. Upon his death, according to the song, the businessmen who were consumers of medicine had to close their shops in Mwanza town and attend the burial ceremony in a remote area:⁴⁸

⁴⁸ Interview and Song, Nhumbu Bumila, Kisesa, July 22, 2007

<i>Sukuma</i>	<i>English translation</i>
Winga kuwelelo shilamiwa Ng'wana mazegenuka, idili lya shimba	He has died, the honored Ng'wana Mazegenuka, Lion-skinned.
Alingosha giti ong'wa mahindi olulaglua Banhu	He was a man like Ong'wa mahindi when he treated people.
Nakung'wisha na minengo, bahila na baningini,	He gave concoctions to infants and children
Nakubinha masamba ohoja makaya.	He also gave (<i>samba</i>) attractive medicine to (<i>Ohoja Makaya</i>), to bring peace in houses.
Nakwimbila mmachalo, Bayaga na Banighini	I am singing in communities, and to the children
nitacheza na nsamba zimenawilisha miji	I will play with attractive medicine, which has made the city flourish,
Aba maduka badaye kingi, Iyigoma mpaga bakafunga, Ukamongo mpaga akalugala, bakunilaga untale Ngalu ng'wana Kasasala	Those with shops in Igoma lamented and closed their shops, Even Kamongo closed his shop in Igoma, crying for the great person <i>Ngosha</i> (a man), a son of Kasasala
Ochila Bugando, kuntwala Mawela hamazishi akaponyiwa.	He died at Bugando Hospital and we took him to Wela Masonga for burial
Ni Koromije bakanjika, Kulidukila bihelaga	Even people from Koromije participated to bury him, even people in Dukila participated
Twite ki ubise lilichene ili welelo litachagulaga nulu ndo nduhu nag'hwe uponyiwa	What can we do, death is not indiscriminate, it takes infants,
Nakunililaga Ong'wana Kasasala	I am crying for the son of Kasasala

The presence of healers and consumers in urban areas provides a mutualistic, symbiotic relationship in which healers receive financial gains and clients receive services they need. This is not to say that healers have abandoned their services in rural areas, however.

2. Ecological

Healers' interactions with the environment are enormous and varied, both direct and indirect, particularly in their search for and gathering of medicinal fauna and flora. In addition, healers, particularly in rural areas, have actively engaged in agriculture and livestock management. These activities, to a large extent, are determined by the quality

and quantity of the environment. Food production and livestock management provides assurance to healers' clients that therapies are supported by a good diet. Therefore, healers are significantly affected by changes happening in the environment.

The environment serves various purposes, including the space for the medical landscape. This landscape includes the built environment where healers decide to operate, the source of medicinal flora, fauna, and minerals, and the places where interactions with clients occur. In addition, the quality of the environment will influence the health conditions of the people and thus help to define the number of people seeking medical care services. However, this environment is threatened by many different conditions. Based upon dynamic and interactive processes in their work that are related to the environment, healers are more likely to effectively describe changes they see happening in that environment. Previous work by missionaries in Sukumaland captured the way in which plants and animals were named based upon their therapeutic activities. Healers, to a large extent, contributed the labeling and recording of the use of fauna and flora in the medical field in Sukumaland. Therefore, healers are the producers, consumers, and disseminators of environmental knowledge; they retain a unique position in environmental and developmental programs, if effectively involved. However, environmental change not only affects availability and access to medicinal resources. The environmental degradation happening through pollution, as well as the decline of forest resources, has had double impacts upon healers' activities. Healers receive clients who suffer from conditions associated with environmental pollution. In addition, healers interact with the environment on a daily basis as through seeking, harvesting and processing herbs. Healers' impact on the environment extends from flora to fauna.

Healers have knowledge and skills related to hunting, taming, and killing different animals. Healers are knowledgeable about populations of animals they use in their therapies, in functions in the field of biological and social medicine, and in their preferred ecological niches. Healers use both live and dead animals in their therapeutic activities. Some animals are killed and their parts are used as ingredients in medicine. Some animals are used for divination to foretell problems and diagnose illnesses. Likewise, some animals are tamed and used by healers to entertain people during social events. In other situations, witches are also known to tame animals that they use for their witchcraft activities.

Healers use the occurrence, sound, and other behaviors of birds, animals, and reptiles to predict events. The occurrence of specific species of animals and their behavior has been used by Sukuma people for early warning about natural disaster or threats to the society (UNEP, 2008).⁴⁹ For instance, an abundance of pangolin in the animal population is associated with an event such as good year for harvesting. Healers are more likely to sell pangolin shells for their use in protective medicine. Seeing an owl or hearing its sound in communities is translated as a sign for grieving. There are different dancing groups in Sukumaland and their knowledge and use of animals is different. For instance, Gunderson (2001) notes that the *Banunguli* dancing group is known as the Porcupine Hunter's Society, and the *Bayeye* are famously known as the Snake Hunter's Society. These dancing groups, according to Gunderson, are capable of investigating and identifying the whereabouts of snakes and porcupines. Trained

⁴⁹ Source : UNEP (2008) Indigeneous Knowldge in Disaster Management, Nairobi, UNEP accessed March 24, 2012 from <http://www.unep.org/IK/PDF/IndigenousBooklet.pdf>

individuals with the support of medicine men then hunt and capture these animals. Snakes and porcupines posed threats to humans, but they were also tamed and used for entertainments. Porcupines were dangerous to crops, especially corn, and snake was dangerous to humans and livestock.

Sukuma healers have incorporated customs, beliefs and traditions in their efforts to sustain their lives. Their approach also entailed protection of animals, particularly threatened and endangered species. Studies have indicated that disregard and negligence of indigenous knowledge has had adverse impacts on resources management practices and on protection of the environment (UNEP, 2008). The use of animals extends to other healers with different ethnic backgrounds operating in Mwanza. Maasai elders, for instance, use animals in prognosis. By reading signs on goat intestines, they could divine drought and famine, social conflicts, diseases, childbirth, peace or war in the chiefdom, and so forth. If the small intestine was found to be empty, drought or famine or hostility and war were to be expected in the chiefdom. However, an intestine that contained a lot of dung foretold plenty of rain, no famine and peace (UNEP, 2008). In order to maintain their livelihood, Sukuma people have developed different kinds of traditional medicines for livestock. The use of medicine for livestock is also common in other societies such as Maasai (UNEP, 2008 p.92)

3. Social

Traditional healing and traditional medicine are more than individual physiological gestures. Traditional medicine accounts for livelihood, and for social formation and structure. Healers in contemporary society have been dually

contextualized. They are seen as health care providers; however, because one group has been accused of participating in albino killings to use in medicine, healers have also been marginalized. Traditional medicine and its actors are widely used in social events as described in the previous sections. They are used to provide social therapies by composing and singing different kinds of songs concerning hope, grieving, political campaigns, and awareness of diseases. The experience of two dancing groups, Bagalu and Bagika, is an example to demonstrate that social structure is determined by medicinal knowledge. These groups evolved through secret societies. In recent times, however, new ideas are emerging about them. These dancing societies provide entertainment and joy during harvest time. Within these entertainments, however, there are competitions that are galvanized by the use of traditional medicine.

On numerous occasions healers have been accused in participating in malicious and clandestine activities that disrupt social fabric and stability. Witchcraft accusations and the killings of elderly women and people with albinism are examples of dark side of the knowledge of traditional medicine. In some incidences, the differentiation between traditional healing and witchcraft is blurred, making it difficult to distinguish between healing and harming. Some healers who were interviewed had different opinions suggesting that traditional healing is different from witchcraft practices or sorcery.⁵⁰ But other healers noted that practicing traditional healing requires curing affliction caused by witchcrafts and, therefore, a competent healer needed to know about witchcraft practices in order to reverse or provide cure for them.⁵¹

⁵⁰ Interview, Samsa Kamo, Butimba Mwanza, February 20, 2010

⁵¹ Interview, Arony Bukebe,-Kisesa, Mwanza, October 4, 2009

4. *Political*

The presence of healers in society creates perceptions and ideas about leaders' roles in shaping a political landscape. Healers are political players that represent a political unit that further contributes to the formation of political ambitions and ideas. Healers have participated as political actors, and also have been consulted by politicians for advice or *samba* (attractive) medicine for authority and power. Politicians have previously and are now offering money to the healers to gain support from constituents among healers. Therefore, the presence of traditional healers in the political arena is both a blessing and a threat. Politicians use traditional medicine to gain power, or protect themselves from opponents. Opponents seeking the same position may also seek out damaging medicines.

The last part of my fieldwork took place at the time when the nation was preparing for the general election in November 2010. Offices at stake included that of the president, members of parliaments, and ward adviser/leaders. The community of traditional healers was involved in the political process in various ways. They were voters. In addition, individuals aspiring for political positions consulted healers for "winning therapies," as well. The medicine these politicians sought was for various purposes: to empower people, to make a candidate attractive to voters, to give candidates the ability to conquer people with their rhetoric, and to make them appear powerful and able to lead. The medicines that politicians sought from healers also had opposite impacts upon the opponents, to render them weak, unconvincing, and untruthful. Healers interviewed noted that they received clients with political aspirations who were willing to pay money for the services they received. Traditional medicine is known and has been

cherished as something that can bring power, as well as influence certain behaviors of people in the community. Power is the capacity of a group or an individual to impose preferences on others, whether the imposition of these preferences may be peaceful or violent (Camacho, 1998, p.14).

Over the course of changing political environments, healers have suffered immensely and often lost power from political processes and development projects that have been established by the government (See Ujamaa, Chapter Three). On the other hand, healers have sought political power by efforts to legitimize the use of traditional medicine to control crimes and secure communities (See Sungusungu, Chapter Four). In dealing with criminals, the power of Sungusungu vigilantism was galvanized by traditional medicine and served two purposes: to ensure that the Sungusungu movement prevailed in securing order and effectiveness, and to empower the leaders to govern by evoking trust and loyalty. To ensure cohesion and to rationalize actions by the movement, trust was a priority. Sungusungu attained trust by performing rituals that set guidelines about secrecy and order within the movement. Rituals involved a particular set of people in the community based on the tasks to be executed. These rituals served many purposes, such as ensuring loyalty to the leaders, the community, and the movement itself.

Sungusungu gave voice to the healers in communities who, as a group, had been marginalized. It also demonstrated that traditional medicine is not only about the health of the body and mind (Du Toit 1971). Traditional medicine in the context of Sungusungu dealt with the health of the society as a whole. It was used to heal communities with “societal illnesses.” Therefore, the use of traditional medicine demonstrates how the power of the medicine influences social and political structures. Traditional medicine was

publicly accepted, despite people's ambivalence about using traditional medicine in health programs. Use of traditional medicines in health programs has been challenged due to a lack of standards.

CONFLICT AND COMPLEMENTARITIES: THE STRUGGLE AND COEXISTENCE OF SUKUMA AND MAASAI HEALERS IN MWANZA

As a frontier area, Mwanza exhibits complementarities and adversarial relations among many actors. There are various forms of endogenous conflict and competition occurring in Mwanza. For example, different groups of investors are competing over resource access and acquisition in the mining and fishing industries. Investors are also competing with inhabitants over issues like mineral rights and land ownership. The government has suggested that inhabitants can own land; however, they cannot own minerals below the surface of their land because minerals are part of the treasury of the government. Large investors with advanced technologies and modern sciences are competing with local artisanal fishermen. These fishermen are accused of using "dark sciences" in order to gain a competitive edge for access to fish resources. Political parties compete with one another for recognition and political power in the region. The field of health and medicine is not spared these conflicts. Biomedical institutions compete with traditional healers over clients and medicinal resources. Conflict also occurs among different groups of healers who compete against one another for medicinal knowledge, power, fame and customers.

Existing studies of traditional healing practices in Mwanza mainly focus on the Wasukuma, the demographic and historical Bantu Speakers who inhabit the area of

northwestern Tanzania known as Sukumaland. This group is now the majority population in the Mwanza region (Wijsen and Tanner, 2002; 2006; Charnley 1997). However, conditions in Mwanza create both an influx and outflow of different actors, including traditional healers. Sukuma healers now compete with many other healers from different regions to attract more customers in Mwanza. These competitions are happening as the region undergoes rapid expansion of mining and commercial fishing, where artisanal fishermen and miners are competing with large scale investors in these industries. The presence of these extractive industries is influencing demographic, labor, diet, and epidemiological changes. The interviews with groups of healers, both Sukuma and Maasai, also showed how climate change and environmental conditions influenced perceptions and medical practices in the region.

A wide body of literature discusses the socio-economic conditions that have pushed Maasai healers into other territories (Ibrahim and Ibrahim, 1998; May 2003). This migration resulted in increased competition with Sukuma healers in Mwanza Town. Varied climatic conditions, in combination with socioeconomic changes, impact the migration of healers and their access to medicinal flora and fauna. Most of the studies on environmental and climate change reveal the disease and climate refugee patterns (Charnley, 1997), but specific study on the impacts on traditional healers is missing. Climate change alters healers' access to medically important flora and fauna, and changing environmental conditions shift bases of knowledge and power among healers. My ethnographic work reveals how the climatic condition is reconfiguring the geospatial positioning of traditional healers (See Chapter 8), as well as the way traditional healers

are addressing new illnesses, exploring alternative understandings of their causes, and responding through changing medical approaches.

As a result of weather patterns and varied climatic conditions, Maasai healers from the Arusha region have increasingly moved their operations into Mwanza Town. My research shows strong links between climate conditions (especially rainfall patterns) and the presence of Maasai healers in Mwanza. For example, my data show more Maasai healers were present in Mwanza town in the summer of 2006, when drought conditions caused water scarcity, agricultural failure and livestock death, than in the summer of 2007, which had adequate rainfall. Migration and the occupation of new places by different groups of healers, due to environmental change, offer both opportunities and conflicts. Migration allows the flow of medicinal knowledge, skills, and resources among healers and across societies. Migrating healers, however, have to acquire land, medicinal resources, and clients in new settlements, all of which are possible factors for tension and conflicts with local residents and government authorities. As a result of changes happening in the environments in which farming and livestock keeping is compromised, for instance, Maasai healers from the Arusha region have increasingly moved their operations into Mwanza Town.

My work reveals the power struggles and competing influences of different groups of healers. This work also shows that healers' choices, and their reconfigurations of traditional therapies, are in response to changes in social structures and environmental and economic conditions. These conditions challenge the sustainability of medical knowledge and practices (Brown, 1995). Political and ecological changes, and their social and health implications, are enormous. The Maasai also revealed the impact of climate

change and changing environmental conditions in relation to the power of medical knowledge.

The Maasai people are considered semi-nomadic pastoralists living on the border of Kenya, in Nairok and Kajiado, and in Tanzania in the Arusha region (Coast 2002). In the past, their lives mainly depended on livestock keeping. Their nomadic life provides the best pastures for their livestock (Western and Dunne, 1979). Because of poverty, droughts, and livestock diseases, since late 1990s, the Maasai pastoralists have been forced to migrate to cities for different kinds of wage labor (May, 2003; Ibrahim and Ibrahim 1998; Coast 2002). Coast also notes that the influences of nation-states, monetization of the traditional economy, formal education, land tenure changes, and demographic factors have all altered the social structure of the Maasai people.

The Maasai migrants engage in a variety of work, such as security guards (a growing industry because security affairs are increasingly privatized), or work selling beads and traditional medicine (Figure 8).

Maasai people are widely known for their knowledge of tropical woodland, a source of herbs for both humans and livestock (Ibrahim and Ibrahim, 1998). Maasai healers gain their medical knowledge from their fathers, mothers, or grandfathers; everyone in their society has this knowledge. Knowledge of medicinal herbs begins in early childhood, when boys and girls herd cattle. Since a



Figure 8: Products sold by Maasai healers in Mwanza

majority of the people in their native land has knowledge about medicine, they migrate into other cities, like Mwanza, to sell medicine as another source of income to compensate for declining economic conditions in their region. In Mwanza, the Maasai have to struggle to gain access to places to sell their medicine. At the same time, they have had to compete with groups of healers operating in Mwanza to demonstrate medicinal knowledge in order to attract more customers. Thus, Sukuma healers also have had to adjust to the influx of Maasai healers in the region.

In my fieldwork, I have observed power struggles among healers staking claims to medicinal knowledge based on changing landscapes and climatic conditions. As one Sukuma healer noted, “Every Maasai claims to be a healer; they are here (in Mwanza) because of economic hardship in their region; they have drought, no pastures for their livestock, and their livestock are dying.”⁵² On the other hand Maasai healers claim, “Our herbs are effective compared to the ones that are available here [Mwanza]. The soil in Mwanza retains more moisture, limiting plants’ ability to retain medicinal compounds. We collect our medicine from Arusha or Tabora [other provinces away from Mwanza], because herbs from those regions are effective.”⁵³

Such rhetoric contrasts, poignantly, with Sukuma acknowledgements that contemporary burdens of viral disease among migrant fishery and mining labor are stretching the limits of their healing abilities. “There is no cure for HIV/AIDS; we have only proliferating “immune boosters.” This statement reflects increased competition between Sukuma and Maasai healers; however, the term “immune boosters” signals both

⁵² Chama Mala, Igoma- Mwanza, August 12, 2006

⁵³ Interview, Oleluca Laze, Milongo Street - Mwanza City, August 10, 2006

an increasingly biomedicalized and commoditized approach to healing. Such contestation, between different groups of healers, as well as between traditional and biomedical approaches, indicates climatic fluctuation impacts healers' migration patterns, definitions about therapies and illnesses, interactions with clients, and access to medically important flora and fauna. Climate change also shifts bases of knowledge and power among healers while it also reveals healers' vulnerabilities and adaptive strategies.

A Maasai healer⁵⁴ noted that a group of Maasai traditional healers in the region experienced challenges such as locating a space to practice medicine. He also related that, in some situations, healers have been harassed and asked to relocate far away from customers. These healers now operate in an open space at a site close to the Milongo River, the major recipient of municipal effluents. Their medicines are exposed to dust and temperature, which



Figure 9: Umbrella shelters for Maasai healers in Mwanza.

affects the efficacy of the medicines. However, in order to justify their presence on a particular street, Maasai healers claim that their presence is for more than practicing medicine. Instead, they occupy the street that, before, was rampant with crime (Figure 9). In Mwanza's competitive landscape, environmental and security concerns emerge as catalysts for power struggles between different groups of traditional healers.

⁵⁴ Interview, Oleluca Laze, Milongo Street - Mwanza City, August 10, 2006

My fieldwork shows that healers are perceived to occupy certain spaces because of social and economic conditions in their regions of origin, especially the Maasai. Maasai healers interviewed in Mwanza counter these claims, saying that the herbs they bring from their own regions are more effective than those available in Mwanza. Maasai healers, who are perceived to be fearless and warrior-like by many non-Maasai (Coast, 2006), also justify their presence in Mwanza by suggesting that they help maintain social order. Says one Maasai healer:

We are here not only for selling medicine, but to provide security in this area. People were killed in this street, and dumped in this stream. We came here and no such event has occurred. The former Regional Commissioner and the City Mayor know that—that is why we are here.⁵⁵

A Maasai healer noted they have relied upon communal and collaborative efforts as a strategy to survive in Mwanza town. Aware that they are away from their homes, they have formed an organization known as *Kikundi Cha Wauza Madawa za Asili ya Kimasai* (literally, “The Organization for People Selling Maasai Traditional Medicine.”) The constitution for the organization, read during fieldwork, stipulates that the organization’s goal is to enable members to reduce poverty by working in informal sectors to raise their living standards.

Healers operating in Mwanza have been restricted from offering therapies for certain conditions. For instance, in the permit by the Mwanza Municipal Office given to Maasai healers operating in Mwanza, it is prohibited for the traditional healers to provide treatment for conditions related to epilepsy, tuberculosis, and cholera. Healers have

⁵⁵ Interview, Oleluca Laze, Milongo Street - Mwanza City, August 10, 2006

argued that patients visited biomedical facilities in the region before seeking treatment with healers. When asked about the act governing traditional medicine, Maasai healers operating in Mwanza noted that many healers do not know the 2003 Traditional Healing Act.⁵⁶

Healers also noted that cultural traditions in Sukumaland have declined over the years. For instance, people in Sukumaland traditionally used protective medicine (*nk'hago*) for natural and man-made harms and illnesses. These protection measures were applied individually and to the community, as a whole. Now, however, the practice is rarely done because people see those practices as backward, old-fashioned, and embedded in witchcraft beliefs. In addition, many people have converted to Christianity and Islam; they see traditional values as contradictory to their new religious faiths.⁵⁷ More often, religions such as Christianity and Islam discourage and disparage people who embrace or maintain traditional beliefs.

HEALTH POLICIES STRUCTURE

Traditional medicine was formally recognized for the first time by the Ministry of Health of the independent government in 1968, through the Medical Practitioners and Dentist Ordinance. This ordinance recognized the presence of healers and their services. Regional Medical officers were instructed to record information on traditional healers and their medical practices, including drugs. The recognition of healers gave impetus for them to establish the first National Association of Traditional Healers, which was known

⁵⁶ Interview, Oleluca Laze, Mwanza City August 10, 2006

⁵⁷ Interview and Song, Nhumbu Bumila, Kisesa, July 22, 2007

as *Umoja wa Waganga Tanzania* (UWATA), and lasted between 1971 and 1974 (Goergen, Bruchhausen et al. 2001). The association was established to unite traditional healers, to establish treatment centers in Tanzania, to offer medical services to people, and to regulate harvesting, marketing and administering of medicinal plants and products (Last and Chavunduka, 1986)

Over the years, the World Health Organization (WHO) has encouraged governments to have national health programs that acknowledge and incorporate traditional medicine into health services. In 1978, for instance, the International Conference on Primary Health Care, held in Alma-Ata, emphasized “Health for All.” This initiative argued that governments are responsible for the health of their citizens and stated that governments should give high priority to the utilization of traditional medical practices and traditional birth attendants, and should also incorporate proven traditional remedies into national drug policies and regulations (Stangeland et al 2008).

One effort by the government sought to promote and standardize traditional medicine. Consequently, the Traditional Medicine Research Unit was established in 1974 at Muhimbili Medical Center as part of the University of Dar es Salaam.⁵⁸ One mandate of the unit was to promote and standardize traditional medicine. In addition, the unit sponsored research expeditions to remote areas and collected medical material to test for toxicity and use (Semali, 1986). In 1979, the National Institute for Medical Research (NIMR) was established. Its mandate was to conduct research on traditional medicine in

⁵⁸ *The National Traditional and Birth Attendant Implementation Policy*. Dar es Salaam. Ministry of Health, United Republic of Tanzania also in the WHO report accessed on February 6, 2012 from <http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf>

order to expedite the government objectives to include traditional medicine in primary health care (Mhame, 1999).

In 1982, the government recognized traditional medicine as part of “culture” and, thus, placed it under the responsibility of the Ministry of Culture. The Ministry of Youth and National Culture made efforts to facilitate collaboration between traditional and western practitioners (Feiermann, 1986; Waite, 2000). Sporadically, private sectors have incorporated clients interested in both traditional and western medicines and food with medicinal values such as minerals and vitamins. This action was aimed at consolidating the customer base to maximize financial gains in an era that is widely dominated by free trade (Jennings, 2005).

Among the interested parties, discussions emerged that traditional medicine offered health and medical care needs to the people; the main question was how these remedies could be standardized. Standardization was deemed necessary to ensure safety for consumers. But this move toward standardization brought forward other complex questions. How can traditional medicines be standardized with all of their diversity, not only among different groups of healers, but also among different approaches that differ based on temporal and spatial conditions? After seven years, in 1989, traditional medicine was transferred to a sector of the Ministry of Health known as the Traditional Health Services Unit.⁵⁹ The emphasis of the unit was on promoting safe use of traditional

⁵⁹ Mhame P. Development of national policy on traditional medicine and strategies for integration traditional medicine into health systems. Paper presented at the WHO consultative meeting on strategy for traditional medicine for the African region 2001-2010, Harare, Zimbabwe, 13 -15 December 1999 also available in the WHO report at <http://apps.who.int/medicinedocs/pdf/h2943e/h2943e.pdf>

medicines for the improved health of the people. Many other associations were formulated in the country in different regions.

The Traditional Medicine Unit was later transformed, in 1991, to become the Institute of Traditional Medicine. The Institute is mandated to seek materials from plants and animals that have medicinal properties and to establish a record of cultural significance for Tanzania. This institute has undertaken a quite number of ethnobotanical studies (Stangeland et al. 2008). According to Hsu (2007), by 1991, the unit had identified over four thousand healers and had tested three thousand herbs. In addition, the unit has produced remedies for different ailments, such as bacterial and fungal infections (Moshi, 2005).

Different Tanzanian presidents have sporadically discussed the importance of traditional knowledge and the need to use traditional healing practices. During his tenure (1985–1995), President Mwinyi acknowledged the importance of traditional medicine and recognized the progress made by modern medical practices. In his keynote speech, the President acknowledged limitations in addressing all of the epidemiological crises of the 21st century (cancer, asthma, heart problems, mental diseases, and HIV/AIDS). He said that, in some situations in which biomedicine has failed, traditional medicine has shown some hope. He emphasized the need to engage people who work in the field of traditional medicine and to do further research to advance the scientific application of traditional medicine in health care services.⁶⁰

⁶⁰Opening Statement by H.E. President Ali Hassan Mwinyi during the OAU Decade for African Traditional Medicine, Proceedings of the fifteenth meeting of the Inter-African Expert Committee on African Traditional Medicine and Medicinal Plants, Arusha, Tanzania, 15 -17 January 2002

President Mkapa followed President Mwinyi and, like the former president, acknowledged the importance of traditional medicine. President Mkapa, in his article, “The Local Pathway to Global Development,” outlined the way in which modern ways of responding to global challenges have ignored local approaches, despite the historical evidence of people relying on indigenous knowledge. Mkapa (2004) further noted that the threats of the contemporary world require acknowledgement and engagement of traditional knowledge.

In the recent past, both national and international governing bodies who have been involved in health and environment policy have acknowledged the presence of traditional/indigenous knowledge. These governing groups have incorporated traditional modes of knowledge into different programs related to health, and to environmental and resource management. In 2002, the WHO initiated its first Global Strategy on Traditional Medicine, encouraging UN member states to develop national policies and regulations to govern traditional medicine and to ensure the safe and effective use of it.

The Tanzanian government, as well as the international community, increasingly recognizes the use of traditional medicine. In Tanzania, government efforts are underway to provide traditional medicine with legal status. The “Traditional and Alternative Medicine Act of 2002” advocates a legal framework for the promotion, control, and regulation of alternative and traditional medical practices, as well as the protection and sustainable management of medicinal plants in Tanzania. This initiative started in 2001.

from (http://fastonline.org/CD3WD_40/CD3WD/HEALTH/H0326E/EN/B1649_6.HTM retrieved January 2, 2010)

At that time, the government approved “traditional and alternative medicine” policy guidelines that advocate, among other things, the recognition and acceptance of traditional medicines in Tanzanian health care, the protection of medicinal plants from illicit trafficking, biopiracy and over-harvesting, and the conservation of plants with medicinal values. The 2003 Tanzanian Health Policy mandated the Village Community Government to appraise, assess and recommend, in particular, local traditional practitioners for registration (URT, 2003).⁶¹ Likewise, international agencies, such as the World Health Organization (WHO) and the International Union for the Conservation of Nature (IUCN), are advocating the application of traditional knowledge to support development processes in Africa.

The World Bank and other international funding agencies have financially supported different national programs related to the use of traditional/indigenous knowledge in health and environmental management. In Tanzania, there are programs in different regions that advocate for and conserve aspects of traditional medicine. In Mwanza, the World Bank is supporting a study by the Lake Victoria Environmental Management Program to investigate medicinal plants in the Lake Victoria basin. Likewise, the Millennium Development Goals project has placed an emphasis on indigenous knowledge and health. These various groups have initiated different programs to restore and conserve resources that have medicinal value that are used by indigenous groups and by traditional healers in different parts of the world (Karjalainen, Sarjala et al. 2010). The recognition of traditional medicine is a dramatic shift from the previous

⁶¹URT (2003) National Health Policy. Dar es Salaam, Ministry of Health
<http://apps.who.int/medicinedocs/documents/s18419en/s18419en.pdf>> accessed on January 6, 2012

consideration by colonials and by newly independent governments, both of which denigrated the roles that traditional healers played in society.

The World Intellectual Property Organization, World Health Organization and World Bank have taken active roles to engage traditional healers in activities such as collection of data and identification of traditional medicine to facilitate acquisition, documentation, dissemination and mainstreaming of indigenous knowledge (Tambutoh et al 2001).

Regionally, the field of traditional medicine also received attention and recognition from African Unity (or AU) previously known as the Organization of African Unity (or OAU). The Inter-African Experts Committee on African Traditional Medicine and Medicinal Plants in the Organization of African Unity (OAU) proclaimed the “Decade of African Medicine, 2001-2010” at a meeting held in Arusha, Tanzania in February 1991 (Stangeland et al 2008 quoting Mahunnah, 2002). Since then, September 1st of each year honors “African Traditional Medicine Day.” Tanzania celebrated the day for the first time in 2003 (Stangeland et al 2008). There have also been efforts to professionalize traditional healing practices in Tanzania, according to Langwick (2011).

CONCLUSION

Traditional medicine is a subset of healers’ livelihoods. Traditional medicine’s existence is embodied in several interconnected fronts: farming, livestock keeping, entertainment, security provision, and citizenship in the community. Different forces, such as political changes, development programs, global market forces, climate change, and resources management practices are affecting traditional healing and its actors in

many different ways. Healers form an important group that describes how people and the environment are affected by changes taking place in a society. Healers are more informed about these changes due to their multiple roles within the society. Healers provide health care services, collect medicinal resources, and perform in traditional dances. Thus, healers and healing practices provide a key to determine structural vulnerabilities among health, dietary, discriminatory, and environmental concerns.

Different groups of healers operating in Mwanza provide useful information to explain how political, environmental, cultural, and socioeconomic changes features in therapeutic processes. For instance, studies have indicated that healers provide health and medical services to more than 80 percent of the population. This interactive process provides an opportunity for healers to describe people's health and societal conditions. Likewise, healers' interactions with the environment are especially intense and frequent; this is a basis of their healing power. Therefore, healers are more likely to observe and describe changes occurring in the environment.

The academic literature on Mwanza's traditional healers has paid particular attention to Sukuma healers and their healing practices in the region among the influx of various cross-cultural and multi-ethnic groups. Mwanza appears to be the heart of the regional influx and is now becoming a medical center where different groups of healers operate. Healing practices are also responding to changes in the region. An increase in environmentally related illnesses, combined with other infectious diseases, has created an increased demand in traditional healing practices in contemporary settings. With high demand, traditional healing practices are rapidly transforming into "products" instead of

“processes.” To a large extent, interactions between healers and clients have become depersonalized.

As it will be described in the later chapters, healers experienced vulnerabilities related to environmental change and conservation practices that restricted access to medicinal flora and fauna. Healers continue to strive to attain legitimacy, power, recognition, credibility, and fame, conditions that are determined by economic, cultural, social and symbolic capital (Samuelsen, 2004). My field experiences show that healers seek capital through the acquisition of new medical knowledge, including the incorporation of aspects of biomedicine. Healers have developed new ways to advertise therapies, have acquired transportation facilities, such as motorcycles, have migrated to new places, and have created new arrays of built environments and medical landscapes.

The following chapters discuss Sukuma and other healers’ perspectives on changing healing practices. Over time, they have conceptualized political and environmental changes in four key ways. The first involves political transformation and development programs (such as Ujamaa villages), and their impacts on the field of traditional medicine. The second factor is related to healers’ struggles to reclaim their identity and recognition in political and security affairs (Sungusungu vigilantism). The third aspect is the growth of extractive industry in the region, including mining and fishery, which has transformed social conditions in the region. The fourth factor concerns the influence of environmental change and its impact upon healers’ medical landscapes and healing practices.

CHAPTER 3: SORCERY AND SOCIALIST STATE FORMATION: UJAMAA VILIGIZATION AND CONTROLLED HEALING

In this chapter I demonstrate how the establishment of Ujamaa villages through the *Operesheni Villagization* campaign shaped the trajectory of traditional medicine in Mwanza, Tanzania. In discussing the transformation of medical practices since Tanzania obtained its independence in 1961, I first note the villagization program and how it initially embraced the field of traditional healing practices and their actors. In the following sections I focus on the changes in traditional medicine as a result of the establishment of Ujamaa villages. Changes in the political systems and processes of economic development in Tanzania have created conflicts, tensions, power struggles and dilemmas in the everyday lives of healers and their clients. In previous studies transformative processes have often been discussed as epidemiological, socioeconomic, and biomedical interventions in politics and economic conditions (Boerma et al. 2002; Caraël and Glynn, 2008; Farmer et al, 2001). However, transformative processes themselves have been rarely discussed as the defining trajectory of traditional healing practices.

Ujamaa villagization was an ambitious resettlement program in the late 1960s and early 1970s, the first such program to be undertaken by the Tanganyika government since

it obtained independence from Britain in 1961.⁶² The Ujamaa project relocated people to designated settlements that were designed to facilitate easy access to social services. In turn, the resettlements freed land for large-scale projects and ensured efficient production processes (Scott, 1998). The establishment of Ujamaa Villages was an effort to create a modernized state capable of using scientific methods for the consolidation and control of labor to maximize production potential. The villagization program, therefore, served two purposes: improvement of the lives of individuals and groups and improvement of economic conditions for industrial production. As such, the villagization process became a symbol of African socialism. However, despite the program's good intentions, implementation was marred by people's resistance and by coercive eviction. Consequently, the benefits of the program were not fully realized.

The Ujamaa villagization experience has created two schools of thought: critics who see the ambitious project of villagization as a failure, and proponents who believe the projects were beneficial in spite of problems. Proponents suggest that the project improved living standards and created political stability, making Tanzania one of the most peaceful countries in the world. They argue that people of different ethnic backgrounds and cultures were allowed to live and work together, thus limiting divisions based upon ethnicity. Critics suggest that the project was a failure, was poorly implemented, encountered resistance from those it aimed to help and did not attain its intended objectives of improving access to social services and development. Critics further blame the economic woes Tanzania experienced over the ensuing years on

⁶² Tanganyika is now called Mainland Tanzania following the union with Zanzibar in 1964.

Ujamaa villagization (Briggs, 1979; Ergas, 1980; Samoff, 1981). A respondent in Mwanza, however, took a neutral position on the impact of Ujamaa villagization by noting assessment depends on one's vantage point. He said:

Personally I feel the exercise encouraged people to go to school when compared to the past. Losses were there because people were forced to settle in new places and they lost their belongings. The benefits are evident particularly in this region, you will see it even today that children are willingly going to school thus helping building a literate society.⁶³

Critics such as Robbins (2008) refer to the work of Scott (1998) concerning the Ujamaa village campaigns in 1973 to 1976. Scott claimed the ambitious resettlement project was conducted without consulting the people; instead, government interests worked to fulfill their own goals, such as monitoring production activities and transforming the citizenry into producers of exportable crops. About 13 million people, or 70% of the population at the time, were resettled in 7,684 Ujamaa villages (Scott 1998 p.245; Robbins, 2008 p.76, p.245). Each village comprised between 200 and 600 households (Mlay, 1986).

While some critics point out that the experience caused many short-term problems, proponents such as Gish (2003) argue that the overall health situation in Tanzania is better now, in comparison to countries such as Ethiopia and Mozambique, because of the socialist health programs embedded in Ujamaa villages. Traditional healers are also among those who observed the benefits of health services when interviewed. "President Nyerere brought good things when he introduced Ujamaa

⁶³ Interview, Fr. Nicodemus Salu, Bujora Sukuma Museum, Bujora-Kisesa, July 1, 2006

villages; toilets were built.”⁶⁴ Another healer said, “Nyerere’s idea was good, imagine smallpox disease was eradicated.”⁶⁵ Gish (2003) notes that, characteristically, the villagization process in Tanzania enabled the entire population to live within ten kilometers of a health facility compared to only 40% of the population in Ethiopia. A significant body of literature shows that healthcare provisions in Ujamaa villages focused on Western healthcare approaches that emphasize sanitation, access to safe and clean water, and preventive and curative medicine (Benyoussef and Christian, 1977).

However, in most discussions about healthcare provisions in Ujamaa villages, what is missing is the discussion about the position and transformation of traditional medicines. There is little or no work that looks at the impact of villagization on the field of traditional medicine. The literature about Ujamaa villages grossly lacks healers and non-healers’ voices on how the project changed traditional healing practices.

Questions arise: why are traditional medicines not given the requisite attention or priority? Why is traditional medicine marginalized and viewed with suspicion? What effects do the political processes of Ujamaa villagization have on the ways in which healers create meaning in their therapies and in their relationships to their clients? To what extent are the villagization changes reflected in contemporary traditional healing perceptions and practices? Furthermore, is the current situation of traditional medicine and practice a product of Tanzanian history and, if so, do the contemporary challenges of traditional healers have anything to do with the history of villagization?

⁶⁴ Interview, Mary Esha, Kisesa, July 8, 2006

⁶⁵ Interview, Neche Hango, Kanyama- Kisesa, August 1, 2006

During the villagization process, traditional healers suffered considerably. These problems the healers experienced in the Ujamaa villages resettlement era have historical roots. After Tanzanian independence, healers formed an association in an effort to legitimize their practices within the twentieth-century state model. However, the government suppressed efforts by healers to identify their position and role in society by banning the healers' association (Heggenhougen et al. 1987 p.44). This ban in the early 1960s was based upon the premise that the country was transitioning to a "modernized state" in which Western medicine was given priority. Traditional medicine was categorized as primitive and its role in the modern state was limited (p.45). When interviewed, healers and non-healers alike noted the chaotic situation during resettlement. Healers lost their medicinal paraphernalia. In addition, the government's modernization efforts discouraged the use of traditional medicine through negative publicity campaigns. Since these events, the position of healers in the country has remained unstable.

Healers were one of the major groups that vehemently opposed moving to the Ujamaa villages due to their ancestral connection with the "therapeutic landscapes"⁶⁶ they created. My fieldwork in Mwanza recounts healers' ideas about sites where healers choose to practice medicine. These sites of medical practices characterize a specific system of traditional knowledge (local and indigenous). These sites are chosen based on their physical environment, economic conditions, political climate, security, and by the cultural characteristics that create interactions between healers and their clients. Therefore, the top-down resettlement and development approach in establishing Ujamaa

⁶⁶ Williams (1998) refers to therapeutic landscapes as "places, setting, situations, locales and milieus that encompass both the physical and psychological environment associated with treatment or healing, and the maintenance of health and well-being."

villages altered ideas and practices related to healers' health and medical practices. Healers had to create new forms of medical landscapes and healer-client interactions.

Government actors, keenly aware of healers' positions as powerful members of communities able to foment resistance to resettling and modern health, attempted to restrict healers' power by dismantling existing hierarchies. The government undertook different measures to render healers less effective in resisting change. The government broke the healers' social powers by abolishing political participation while the healers' practices were depicted as backward and linked to witchcraft. Healers received harsher treatment than their counterparts during villagization. For example, healers' properties, such as their houses, were demolished and their medical materials were confiscated, burned, and destroyed. Accused witches, mostly traditional healers, became the victims of harsh coercive treatment and punishments, particularly when found in possession of unusual materials that were used for their practices. Interviewed healers and non-healers in Mwanza noted that the suspects were taken, remanded, and tortured.⁶⁷

Healers in rural areas were more likely to be farmers and/or healers. Many of them owned livestock; thus, the effect of environmental change would have multiple impacts on rural healers' livelihoods and medical practices related to habitat. The effects of land degradation and environmental change on traditional medicine are enormous and impact crucial conditions such as accessibility, availability, affordability, and adaptability of medicinal flora and fauna (Anyinam, 1995).

⁶⁷ Interview Fr. Nicodemus Salu, Bujora Sukuma Museum, Bujora-Kisesa, July 1, 2006; niche Hango, Kanyama-Kisesa, August 1, 2006

Because of these multiple roles and concerns, government actions threatened healers in many different ways. Some healers completely abandoned their activities. Those who continued practicing medicine had their practices compromised and changed due to lost materials and to the negative publicity they received. All these conditions retarded the development process of traditional medicine in Tanzania. To understand the political and Ujamaa village processes, this chapter documents how the development project of Ujamaa villagization influenced healers' relationships with their clients and with the meanings of their therapies in the physical environment. Before delving into the discussion about ways in which Ujamaa villagization transformed healing perception and practices and how its impacts still prevail in contemporary settings, I first discuss the idea of reconfiguration of settlements as a mechanism for state control.

TANZANIAN STATE AND SOCIAL CONTROL

Historically, states strive to create conditions that will enable them to govern their people in a way that ensures the population participates fully through controlled labor in economic development programs (Ferguson and Gupta, 2002). Efforts by states to reconfigure settlements are used to consolidate power and to counter the effects of unbalanced resource distribution (both renewable and non-renewable) and labor, while creating optimum conditions for utilizing scientific and technological innovations.

Reconfiguring territories in the modern era, such as the creation of Ujamaa villages, deviates from the earlier colonial innovation of territoriality introduced to Africa to modernize states (Mozaffar and Scarritt, 2004). Prior to colonialization, historical patterns of migration and settlement produced territorial concentrations of people who,

over time, were reciprocally linked by language, culture and religion (Mozaffar and Scarritt, 2004; Gray, 2002). These traditional territories were characterized by shared cultural identities, definitions of landscapes, environmental practices and labor conditions.

According to Murphy (1990), the traditional territorial discourse is better understood by examining the relationship between ethnic groups as an historical and contemporary concept of boundaries. Murphy also argues that territory must be seen in terms of the dynamic relationship existing between an area and the social processes and ideologies that give it meaning. Traditional territorial formation, for instance, shows that pastoralists demarcate their territories when exploring their environment. They create imaginary and fixed boundaries of territories in their movements using specific objects, such as water wells and grazing fields (Kratochwil, 1986; Gewalt, 2002). By example: in southern Gabon, native communities created cognitive maps to accommodate functional regions geared to trade as well as to clan ideologies of common origin when solidifying a close trading relationship (Gray, 2002). In contrast, Gewalt (2002) notes that the European-derived, arbitrary boundaries that demarcate the African continent were established to control labor and resource access. Gray (2002, p. 176) concludes modern territoriality during the colonial period sought to fix people with the same ethnic identities and relationships through the bureaucratic textual space of map and census.

Similar approaches have been used when the social relevance and political salience of ethnic groups in the assigned territories stem from the strategic use of predetermined markers by a group of people to foster internal group cohesion and to differentiate themselves from other groups (Mozaffar and Scarritt, 2004). Colonial rule

established the political, social, and economic conditions for the emergence of ethnicity as a strategic political resource in Africa (Mozaffar and Scarritt, 2004).

The established imaginary and fixed boundaries for both traditional and modern territories mediate and restrict exchanges between one territory and another. Furthermore, boundaries allow for internal conditioning of territorial members' relationships with the natural environment and with production activities. The newly created territories, such as those of Ujamaa, had a different make-up and were defined by people working together in communal farms and living in created settlements according to the plans of the government. States tend to create their territories and sub territories based on their intended images and ideologies. In creating their own images, states deploy unitary strategic interventions in programs such as health, education, economic activities, agriculture and policing interventions (Aretxaga, 2003). The newly created Ujamaa villages strove to ensure that ethnic divides were broken and a unified language – Swahili – was used. The assumption was that the creation of a cohesive language community would make the adaptation and implementation of development projects easy.

State interventions through the creation of roads, schools, hospitals, and other programs transformed social relations by increasing the integrative capacity of different ethnic groups while also diminishing cohesive power within those groups. The disintegration of internal cohesion was not a concern for the government; however, this lack of cohesion became an obstacle to attaining the government's desired goals because people had to forge new relationships while understanding the process of embracing the government programs. Traditional governing systems were, to a large extent, altered mainly because people had to establish new relationships with other migrants in newly

created settlements. A retired teacher in Mwanza noted these lifestyle changes in Ujamaa villages. In pre-Ujamaa settlements people had strong bonds with other members of the community; this familiarity galvanized social relations and the need to help one another. It took some time for people to establish new relationships in Ujamaa villages because these were new environments hosting groups of people with different ethnic backgrounds.⁶⁸ A veterinary officer noted this transformation of human relations. Before Ujamaa villagization people farmed together and helped one another in times of misfortunes and during mourning and burial ceremonies. However, culture and customs were mixed in the newly created settlements. Some original cultures and customs disappeared. Ujamaa villages brought people from different ethnic backgrounds such as Wakurya and Wajaluo (mainly fishermen) and Wasukuma (farmers and livestock keepers) into new settlements. The result was a mix of cultures.”⁶⁹

State interventions to modernize African people have been applied in other fields to control demographic transition by the use of methods deemed appropriate. Hunt’s (2005) work captures historical trends that have been used in Africa that include providing formal education, employment opportunities, and contraceptives to women as ways to improve their living standards.⁷⁰ Similar modernization projects were undertaken in Tanzania before the introduction of Ujamaa villagization. The Priest at Bujora Museum in Kisesa recalled, “Before 1974 there were pilot projects to modernize agriculture in Mwanza. For instance, there was a farm at Nyashimba –Magu that was fumigated with pesticides. This farm was intended to demonstrate modern farming

⁶⁸ Interview, Wilson Solonda, August 1, 2006

⁶⁹ Interview, Gamella Lugwisha, Kisesa July 5, 2006

⁷⁰ 2005 –“Fertility’s Fire and Empty Wombs in Recent Africanist Writing”

practices before the implementation Ujamaa villagization in 1974. The goal was to train settlers for the time when new policy was introduced that would have people living in close proximity for easy access of social services.”⁷¹

There were deliberate efforts by the states to involve their people in economic, legal, education and health programs through villagization. As shown in some literature, even as landscape and boundaries created territories for control by states, people could use those boundaries to escape control (Scott, 1998; Scott 2009). Government officials believed that, by establishing a concentrated governing system, the goals of social order, security, and control of production processes could be attained. Social services would be effectively distributed and development programs monitored if the settlements were reconfigured. To fulfill its goal of governing, managing resources, and controlling production activities the government emphasized villagization programs, nucleated societies that could easily be monitored. The distribution of parcels of land and recommendations to grow particular kinds of crops became the mundane goals of Ujamaa villages. This state control is not dissimilar to what Scott showed was the basis for state building projects in other areas, such as the complete abolishment of people’s original residences in “the Padi-State” of Southeast Asia (Scott 2009, pp. 42-43, 56), or the resettlement of people in the Shire Valley Project in Malawi (Scott, 1998, p.227). Similar actions by the Office du Niger by colonials (Bonneuil, 2000) were repeated in an independent Tanzania under what was called “African socialism” as described in a later section.

⁷¹ Interview, Fr. Nicodemus Salu, Bujora-Kisesa, July 1, 2006

Over the years, the international community has praised the government of Tanzania on many occasions for its enduring peace and social cohesion (Van Der Linde, 2001; Kessler, 2006). One factor mentioned in this stability is the capacity of the government to limit the presence of ethnic divides through use of a common language – Swahili. This effort started in 1965 when Nyerere sought to unite the country through this common language. At that time he restricted the use of native languages other than Swahili in schools and in political meetings (Bessire, 2000 p5). Some argue that such government decisions are associated with losses of core elements of traditional medical knowledge: language and culture (Jangu, 2004). As villagization pushed diverse peoples to live together, it also pushed them to speak the unified language of Swahili. Consequently, cultures and identities were blended or lost. These losses affected traditional healing practices.

CONSOLIDATING STATE POWER: ABANDONING CHIEFDOMS, LIMITING HEALERS AND DIVINERS' ACTIVITIES

Healers are political players representing a political unit that contributes to the formation of political ambitions and ideas. Numerous reports suggest that healers were key players in chiefdoms, and that their presence ensured security, reproduction and production processes of chiefdoms (Wiljsen and Tanner, 2002; Bassire, 2002; Feierman, 1990). In addition, healers in societies are known for their role in offering protective medicine for people aspiring for political positions. Bassire (2002) notes that before independence chiefs interacted with healers most often in their search for protective medicine of their bodies, houses, and chiefdoms (p. 58). Likewise, modern politicians

continued to offer money to the healers as a means of attaining their political ambitions (Moore and Sanders, 2001; Brain, 1982). Therefore, there is a mutual understanding and interplay between politicians and traditional healers. Despite the different roles that healers have in political processes, they have suffered immensely from policies and development projects initiated by the independent government. Healers' roles in political systems were reduced when chiefdoms were abandoned in 1962, a year after independence. The ostensible goal of restricting chiefdoms was to restrict power owned by chiefs; however, chiefs were also part of the organization structure that embodied the field of traditional medicine. Therefore, the government decision to abandon chiefdoms had cascading effects on the community of traditional healers who interchangeably shared power in the political system with chiefs and their subordinates.

The pre-colonial period characterizes the role of chiefs as rulers and religious leaders whose authority was rarely challenged. Chiefs served as judges, leaders in war, administrators of chiefdoms and as sacred authorities in overseeing the well-being of their people and crops (Bassire, 2000, p. 26). The stability of a chiefdom was determined by the chief's ability to control social and ecological processes, and to resist attack or invasions from other chiefdoms (Feierman, 1990). Chiefs supervised and carried out rituals to improve people's livelihood and the welfare of livestock (Wiljsen and Tanner, 2002, p.76). Chiefs were considered "people of peace," because of their assumed spiritual connections that were essential for leadership and authority (Bassire 2000 p.18).

Under colonial rule, chiefs were controlled or manipulated to fit into the objectives of the colonial powers. For example, the Germans were largely unwilling to allow chiefs to operate and killed some (Feierman, 1990), while British colonial rulers

used an indirect governing approach utilizing chiefs as mediators and intermediates. Bassire (2000 p.25) notes that with the advent of the German and British colonial administrations, chiefs were stripped of their magico-religious influence in the community and royal objects were no longer exclusively associated with the ruler's sacred nature. She further notes that these objects came to represent the chief's loss of authority. However, despite restrictive conditions, many chiefs survived the pressure of colonial powers and retained or shared power with colonial rulers.

Chiefs relied on diviners for rituals that entailing production, health, and security. Chiefs supervised rituals for rain making in their efforts to ensure territories had adequate precipitation to grow food. Chiefs who lacked medicinal knowledge lured experts who could perform rituals to control weather and diseases. Healers' legitimacies, authorities, and influences were determined by their success in controlling such social, environmental, and security events. In Tanga, according to Feierman (1990 p.148), peasants challenged the British authority for selecting a chief who failed to tame weather and bring rain. The peasants claimed the chief lacked medicinal knowledge, was deemed unfit to govern, and was asked to resign. In such circumstance chiefs sought protection medicine for their physical wellbeing, houses, and chiefdoms (Bassire 2000 p.58). Wijzen and Tanner (2002 p.90) quoting (Cory, 1951) summarized the ritual functions and actions of chiefs in Sukumaland:

The carried out rituals to aid the agricultural cycle, consultations with rain makers about the prospects, the preparation of promotive magical medicines, the ritual preparations of seed and the soil, the following of personal taboos such as the chief shaving his head so that the hair grows with the crops, the ritual protection of the growing crops from bird and animal pests, and harvest celebrations with the ritual eating food from the new crops...(A chief) had overall concern for adequate and well

distributed rain on which the survival of his people and indeed his own political and social survival depended.

Chiefs collected and allocated resources and assigned responsibilities in their territories with the powers gained through medicines combined with charisma. Because of these powers, the relationship between chiefs and healers was mutualistic; the political structure of chiefs created identity and autonomy for traditional healers, such as diviners. However, chiefs' authorities were halted following the abolishment of chiefdoms by the independent government under TANU, led by Nyerere in 1962 (Askew, 2006). The post-colonial period is characterized by the need of the government to consolidate administrative power for economic and security reasons, illustrated by Nyerere's strategy to push through his agenda unhindered by political rivals. A respondent in Gallu explains how chiefs were removed from power, noting:

Ujamaa villagization was an idea, which began when Tanzania became independent in 1961. In 1962 soon after independence Tanzania, through TANU – Tanzania African National Union – as a ruling party, chiefs and their advisors were removed from power. But, these (chiefs) were the people that assisted TANU to win election. Nyerere did not see any future role of chiefs and their assistants in independent government.⁷²

Therefore, the government took deliberate action to restrict chiefdoms and this action had direct and indirect effects on the power of healers/diviners in society. Since the early 1960s, traditional royal objects were no longer used publicly when Sukuma rulers lost their political powers. The use of royal regalia and objects would have been

⁷² Interview, Andila Makele, June 28, 2006; the retired village Chairman in Gallu village – Ukerewe

regarded as political defiance of Nyerere's new government initiatives and the eventual abolition of royal political authority (Bassire 2000 p.56).

Yet, healers had different roles in communities, and not all of them were linked to chiefs or elevated in the position of assisting chiefs, even though restriction of chiefs was one of the approaches that the government used to dissociate healers (diviners) from political structures. Despite the abolishment of chiefdoms, diviners readjusted and continue to exist. Wiljzen and Tanner (2002), quoting Feierman's work about Shambaa traditional religious rituals, note that there was a loose fit between chiefs and diviners that had allowed diviners to survive at the time when the chiefs lost power. Healers in societies assume different roles such as resolving conflicts, supporting administrative agencies in communities (Feierman, 1990 p.263) and expressing their opinions about health issues, wars, social affairs, and political systems using songs (Gunderson, 2010).

Despite healers' efforts to justify their roles in societies, their practices have been increasingly questioned. In one report in Sukamaland, a diviners group of traditional healers was accused of causing the killings of elderly women. These killings targeted elderly women who were accused of witchcraft identified as the cause of disease, death, and infertility. Because of these accusations, the government placed restrictions on healers who do divination to curb their presumed instigation of violence in communities. Healers, on the other hand, have challenged the government decision and many have continued performing divination, knowing that the government can hardly enforce laws that restrict healers from performing divination. Interviewed healers argued that divination is an important aspect in the field of traditional medical and is used for

diagnostic and prescription purposes (Details on divination Chapter 2 and are included in other chapters)

UJAMAA VILLAGES: RESETTLEMENTS IN ENGINEERED UNITS FOR DEVELOPMENTS

In his inaugural speech for independence, Nyerere highlighted poverty, ignorance and diseases as obstacles for development (Jonsson, 1986). In order to address these challenges, the government initiated different strategic interventions, including “owning means of production by people for the benefit of the people” (*Mali ya umma kwa manufaa ya umma*). Consequently, privately owned means of production, such as industries and farms, were nationalized. Nationalization of industry was followed by the introduction of Ujamaa villagization, where engineered production units with controlled labor were created. The newly created settlements were designed to facilitate easy access to social services such as water supply, health clinics, sanitation departments, schools, and other public infrastructure. The purpose of bringing social services in the new settlements was to create a healthy and productive society that would be able to feed itself and also produce surplus for foreign exchange.

The three pillars for Ujamaa, freedom, equality and unity (Yang, 2008), act as a symbol through which African traditional life, activities, and resources could be shared to improve the livelihoods of the people in the villages (Guggenberger et al 1989). Nyerere’s socialist thinking, borrowed from countries such as Russia, China and Eastern European nations, governed the ideas behind Ujamaa (McHenry, 1994). An 80-year old respondent in Gallu-Ukerewe noted Nyerere’s goal was to facilitate access to social

services by bringing people together where social services such as water, schools, hospitals and roads could be expanded.⁷³

A significant amount of literature has emerged covering the ideas, concept, ideology, practices, and impacts of establishing Ujamaa villages in Tanzania. Ujamaa villagization signifies intervention through the governing of people's lives and thus the shaping of the production process. Villagization changed how people produce and how they operate in communities within their social structures, as well as how they access social services (Askew, 2008; Hyden, 1980; Mlay, 1986; Moore, 1979; Scott, 1998). This change is what Foucault termed "governmentality" or a redefinition of the micro settings in rural communities for social control in order to cope with the macroeconomic conditions that characterize the global economic system.

The literature related to Ujamaa villagization finds a wide range of topics that address the processes of governmentality. They include: African socialism and Nyerere's ideas about the need to create Ujamaa villages (Ergas, 1980; Hyden, 1980; McHenry, 1994; McKay, 1968) the need for rural development through resettlement programs (Huizer, 1973), the impacts of the implementation of Ujamaa villages, such as the loss of properties and coercive resettlement (Ergas, 1980), the resultant impacts after implementation, such as tensions over land and livestock keeping (Moore, 1979), the successes and failures of the project (Shao, 1986; Shivji, 2002), the impact of Ujamaa villages on the environment (Mlay, 1986; Shao, 1986; Sheridan, 2004), the people's characterization of the Ujamaa exercise in contemporary settings, (Askew, 2008), and

⁷³ Interview, Andila Makele, June 28, 2006; the retired village Chairman in Gallu village – Ukerewe

the relationship of Tanzanian Ujamaa villages with other, similar projects in other countries (Scott, 1998; Bonneuil, 2000)

A majority people interviewed (both healers and non-healers) noted that Ujamaa villages were established to provide access to social services. Despite their participation in agricultural activities, many were not aware that they were also brought together to form production units. This lack of knowledge is mainly attributed to the propaganda used to disseminate the ideology of Ujamaa villages as units for social services rather than engineered production units.

The creation of Ujamaa villages in Tanzania remains as the legacy of Mwalimu Julius Nyerere, the first president of Tanzania. Nyerere's vision of development through Ujamaa villagization is seen in literature and in people's opinions captured in songs in the contemporary settings. Askew (2006) reviews lamentation songs about the founder of Ujamaa villages, Nyerere. She notes that, despite the popularity of the Ujamaa project in the 1970s, nowhere in more than 100 songs is Ujamaa mentioned. She attributes this silence to the ambiguous nature of Ujamaa and to the way in which villagization projects shaped local ideologies in Tanzania, a nation that has transitioned from socialism to a free-market system. This transformation is captured in my fieldwork with *Balingi* (Song composers and leaders for Sukuma dancing groups) in Mwanza. A Sukuma *Ningi* (singular for a song composer) Busele Maliga in Mwanza shows his admiration for Nyerere's leadership and for the way Tanzanians have accepted his death and embraced new ideologies under new leaders, including the President of *Awamu ya Tatu* (Third phase - Benjamin Mkapa) and *Awamu ya Nne* (Fourth phase- Jakaya Kikwete), in his song:

Tanzanians let us keep the cohesion that was left by Kambarage Nyerere.
He left the world and he was our guide and our protector.
Since 1961, Nyerere was our leader, until the government decided to give him a break.
He was ill and they decided to take him to London, even there they failed.
God had decided [to take him].
The day he passed away, I prayed to the God, because we have come from far.
Let us be active with Mkapa, to make it! [to succeed].
I now favor *kasi mpya* (new vigor), *ari mpya* (new morale), Ng'wana Busalu, Tanzanians.

The resettlement program through villagization transformed social groups and arrangements that had already begun taking shape during the colonial period. The colonial period's interventions, to a large extent, changed the self-governing system of rural communities that were maintained by chiefs in many places. However, colonials established settlements in areas near farms as a way to consolidate labor, and thus altered existing social structure (Havnevik, 1993 p.195; Kikula, 1986 p.18-19). The difference between the colonial resettlement programs and those of the Ujamaa villages was the stratification of social groups. Colonial resettlements, most often, were comprised of young adult members of a society – mostly men – who were settled in farming estates (Heggenhougen et al. 1987 p.17). In Ujamaa villages, on the other hand, the programs involved resettlement of entire populations in designated places to maximize resource exploitation through controlled labor. The availability of resources, labor, and markets within the Ujamaa village resettlements created conditions for both external and internal actors to contest for control of African environmental landscapes.

Ujamaa villages were formed to enact directed and intentional change that was motivated by the idea that development can only be attained by creating controlled production-engineered units (Escobar, 1992). The creators of Ujamaa villages adopted

principles similar to those used during the colonial era in places such French Sudan (now Mali), through the well-known Office du Niger (Bonneuil, 2000). Dubow (2004) argues that such colonial practices utilized in the Ujamaa villages were not merely derivative: they were also shaped by local concerns, were sensitive to context, eager to exploit indigenous resources, and were capable, from an early stage, of making a distinctive contribution to imperial Western science. Van Beusekom (2002) discusses a development theory characterized by the role of rural communities and the practice of representation. She writes that the Office du Niger was established in 1932 by the French government for development (*mise en valeur*) purposes. The development program initiated by the French colonials through the Office du Niger in French Soudan, part of France's "plan for imperial autarky" (p. xxvi), was established to serve the twin purposes of production of profitable cotton and improvement of living conditions among the populations in the region. Both approach and practice were aimed at bending African social communities and farming practices toward economic development and improved living standards. Within this context, Van Beusekom argues that "development" is an ambiguous term and has been defined in many different forms by different authorities.

Van Beusekom's synthesis of historical data describes the French Soudan region as sparsely populated; the Office du Niger needed to geographically concentrate this potential labor population in order to maximize production potential. Governing officials viewed the native agricultural systems as backward, limited by existing technology, and as deficient, as indicated by the poor nutritional conditions of the local populations. Van Beusekom attempts to reconstruct the ways in which the settlers (resettled people) and Office du Niger bureaucrats negotiated development theory and practices in response to

African farmers' resistance. The farmers' resistance was based upon their understanding of what development entailed. Settlement practices such as irrigation and "vulgarisatio", or crop-farming on non- or partially irrigated land, were introduced with the aid of a plow and by the restriction of population movement. In *The Anti-Politics Machine*, Ferguson notes "the development discourse is the name not only for value, but also for a dominant, problematic, or interpretative grid through which impoverished regions of the world are known to us" (Ferguson, 1994, p. xiii). One school of thought such as neoliberalists and social evolutionists posits that development is determined and measured by economic success (Owusu, 2003). Another school of thought advances humanitarian considerations as the determinant of developmental success (Petrasek, 1998).

By adopting a social evolutionist approach, according to Van Beusekom, the Office du Niger advocated the use of the plow, crop rotation, and scientific management practices to transform "primitive" agricultural practices to produce cotton and peanuts to feed the textile and oil industries in France. In order to achieve this objective, lands were converted into farms and new settlements were purposely established to monitor labor (2002 p.95). These programs, however, ignored the historical context of culture, the political knowledge base of the local Africans, and the people's interactions with the environment. Thus these programs were likely to fail. The African knowledge base was assumed to be less efficient during the development process. Unlike the example of the Office du Niger, the Ujamaa villages projects embraced both schools of thought: that development entails economic success and that access to social services to improve living standards of the people will, in turn, make them healthy and effective in production activities. The Ujamaa villagization health system was restructured in order to

reduce morbidity and mortality rates, to cut down on health-related costs, and to ensure a healthy and efficient labor force.

Development approaches to control labor in socially engineered production units via development agencies, what Ferguson (1994) calls the “development apparatus,” put emphasis on Western ideas as essential to improve the livelihoods of African people and to advance their economic development. Van Beusekom (2002) refers to this approach as the social evolutionist paradigm that characterizes Western ideals and practices at the top of the hierarchy and as necessary to achieve economic development. In an analogous situation, African communities are depicted as passive recipients of Western ideas, technologies, economic programs and cultures (Bonneuil, 2000; Ferguson, 1994; Scott, 1998; Van Beusekom, 1997; Van Beusekom, 2002).

Implementation of Ujamaa villages, to a great extent, ignored local knowledge in deference to this “development apparatus.” Critics claim this approach contributed directly or indirectly to the failure of that project (Lorgen, 1999). A reliance on limited Western ideas and programs for state modernization programs creates challenges when these programs completely neglect traditional, long-standing ways of life among local inhabitants. These established development projects affect social structure in many different ways. Van Beusekom (2000; 2002) notes the way in which the Office du Niger impacted the economic and social conditions of individuals in the region, in relations between settlers (resettled Africans) and officials, and in the terms by which the settlers understood and interacted with their physical and human environment. She suggests that development is not a static process; rather, development transforms to accommodate different physical and human conditions in different temporal and spatial conditions.

Failure to acknowledge the contribution of local inhabitants would lead to failure. According to Van Beusekom, the Western-initiated programs neither produced enough cash crops nor improved the intended social conditions of the settlers.

Van Beusekom criticizes the introduction of new approaches that do not account for the knowledge existing in particular communities. She notes, for instance, that African people had interacted with nature, creating their own agrarian methods to enable them to survive in various environments. Ferguson (1994) echoes Van Beusekom's concerns by observing how Western ideas are implemented without taking adequate consideration to the historical and cultural conditions that characterizes human relationship with their natural environment. Consequently, failure by the development apparatus to acknowledge the indigenous methods provided an opportunity for community members to employ different tactics of resistance, hampering the execution of development projects, leading to the massive failure of the big projects. The failure of acknowledging the values embedded in traditional societies manifested themselves into challenges and resistance by the natives who use different strategies to resist such forms of governance (Scott, 2009).

The Office du Niger programs resettled Africans against the will of the people in various regions. Likewise, conditions at the Office du Niger were not attractive to the settlers (local inhabitants), and the division of labor created economic discrepancies among families. Government officials brought settlers to designated places by force and made these settlers work for a specified number of hours to produce a certain number of products or suffer sanctions. Government officials controlled this program by ensuring that labor organizations in the created territories were monitored (Van Beusekom 2000; 2002).

Van Beusekom's work indicates that development theory and practices achieved in the region were based on a negotiation process involving different actors (2002). Despite the authoritative role of the office and administrators, most of the activities were conducted by concession. It is evident that the transformation of the Office du Niger suggests that development initiatives transform continuously in order to accommodate different cultural values, social conditions and political structures. For instance, the struggle and conflicts that emerged forced the officials at the Office du Niger to redefine the roles of the office through concessions and adjustments. Newly initiated policies were more adaptive and accommodative to settlers. The agricultural practices and managerial initiatives that evolved used both African knowledge and European expertise in fulfillment of the development goals. Van Beusekom challenges the idea of development that ignores historical consideration and existing traditional practices and knowledge, as she notes that introduced development projects in the developing world more often embrace Western ideologies and assumptions of cultural superiority.

These lessons from the Office du Niger were not heeded during the establishment of Ujamaa villages. In the villages program there are similarities and parallels to the Office du Niger projects; similar approaches were employed to create large settlements without embracing people traditional values, needs, and social systems. In these programs, according to Van Beusekom, development theory puts emphasis on the ideology of development based on the single approach considered by social evolutionists. The process was concerned with the transformation of African communities to create adherence to colonial values while ignoring the values within local communities. The Ujamaa village experiment began in 1967 and the total implementation of the Ujamaa

villages' project was undertaken in 1974. The implementation of the Ujamaa village project was governed by the Arusha Declaration in 1967, the proclamation of *Ujamaa na Kujitegemea* (Socialism and self-reliance) and *Ujamaa* (family-hood). Governing bodies abandoned the free market approach sought early on when Tanzania obtained independence from the Britain (McGee, 2008).

ACHIEVING DEVELOPMENT IN UJAMAA VILLAGES THROUGH "AZIMIO LA ARUSHA" (ARUSHA DECLARATION)

In February 1967, the Government issued the Arusha Declaration, which outlined the policy of *Ujamaa na Kujitegemea* ("Socialism and Self Reliance"). The declaration advocated public control of the economy and development through self-reliance, social equality and rural development. The Arusha Declaration placed the means of production in the control of the public (nationalization of the means of production), prevented government officials from participating in private economic activities, encouraged a policy of self-reliance with limited or no dependence on foreign capital, emphasized agriculture and rural development, provided public access to health care and education, and created the Ujamaa villages (McGee 2008; Sanders, 2008). The purpose of Ujamaa villagization was to advance development processes using scientific methods in agriculture, particularly in rural areas where a majority of the people resided. The establishment of Ujamaa villages entailed supplying social services to the community members, thus making them healthy, efficient and accountable for production activities.

An enabling Act of Parliament was passed in 1973.⁷⁴ This act allowed the president to declare any area of Tanganyika a candidate to fulfill villagization goals. Likewise, the Minister for Regional Administration gained responsibility to regulate farming activities in any of the selected areas. The Ujamaa Villages Registration Designation and Administration Act of 1974 paved the way for every village to become a multi-purpose cooperative society. The goal was to establish villages that would accommodate 250 to 300 families.

The government sought to improve the economy and people's livelihoods; the rhetoric used to promote this goal highlighted four aspects important for development: people, land, clean politics, and good governance. Villagization became a formal rural-development policy advocated by President Nyerere (Moore, 1979); he emphasized that the means of production should be owned by the people for the benefit of all people in the community. Land use was given priority. Populations would be centralized and guided by expert leaders in agriculture and livestock keeping to encourage economic development. Kilasara notes, "Through clean politics we get clean leaders who in turn with good governance formulate the right policies which guide the peoples' interaction with land to achieve development."⁷⁵ Advanced agricultural practices in these villages were a priority to stimulate economic development in Tanzania. In 1975 the Ujamaa Village Registration, Designations and Administration Act became law. This act entailed cancellation or modifications of rights to, titles for, and interest over parcels of land.

⁷⁴ URT (1973) The Tanzanian Rural Lands Planning and Development Act, No 14/1973

⁷⁵ http://www.tzaffairs.org/category/politics/page/7/?wpmp_switcher=desktop

The land that was the driver for developmental goals, particularly in *mahame* (former homesteads before Ujamaa villagization), was also valued by local inhabitants as the symbol of identity, the source of subsistence, and as the site of spiritual connections. The customary land rights of majority Tanzanians were not acknowledged (Hodgson, 2002). Before the establishment of Ujamaa villages, people were scattered; they had their choice of farmland suitable for agriculture and livestock keeping that was safe from wild animals. Government officials' and local inhabitants' varied interests and valuation of land shaped the outcome of Ujamaa villagization, seen in the resistance among local residents to move to the designated settlements. The government then employed coercive action to relocate people in new settlements, as Sanders (2008 p.114) notes:

While for many years Nyerere stressed that the establishment of *Ujamaa* villages must be voluntary, the voluntary eventually gave way to the compulsory. This culminated in Operation Villagization in the mid-1970s, during which time around 5 million people – about 50 per cent of the rural population – were forcibly moved into *Ujamaa* villages. 'Far from achieving . . . populist legitimacy, the villagization campaign created only an alienated, skeptical, demoralized, and uncooperative peasantry for which Tanzania would pay a huge price, both financially and politically' (quoting Scott, 1998: Coulson, 1982: Ponte, 2002)

The World Bank supported the villagization program, emphasizing that, "villages should become the vehicle for the 'Transformation Approach' to rural development" (Moore, 1979). The goal of these villages was the integration of economic and social activities through the embrace of innovations in education, training, and demonstration projects. The Ujamaa villages were designed to enhance production of food and cash crops, industrial raw material, and new jobs. These activities were supported by agricultural experts who offered advice on ways to improve farming techniques through use of modern equipment. Technology became one of the ideological keys for

development, as one respondent who owned five acres noted when asked if the land he received was sufficient, “With good technology in farming this land is enough; however, it is not enough in a real situation we have now of lacking technology.”⁷⁶

Moore explains the Ujamaa village was an official program for managing scarce capital resources while mobilizing more non-fiscal resources through “self-reliance” and the generation of labor-created capital. Beinart (2002) argues that the scarcity problem could be converted into sufficiency and abundance by intensifying agricultural activities through use of modern technologies. In order to achieve these labor objectives, the infrastructure system was a priority. Most of the newly established Ujamaa villages were established along the roads. The government made efforts to ensure that farm equipment (plows, oxen, pesticides, and fertilizers), as well as experts to advise on agricultural activities and livestock management, were available.

The Ujamaa village bureaucrats’ assumptions followed the colonials’: that the pre-colonial period was characterized by inefficient systems in which human beings had limited interactions with the environment due to the lack of knowledge, weak technology, and scattered communities. Colonial administrators from Germany and Britain, for instance, shifted labor from food production to the creation of a surplus of labor-intensive nonfood cash crops such as cotton (Little, 1991). Efforts made since the colonial periods have focused on modernization and intensification of agricultural activities through the use of machines, experts, pesticides, and fertilizers. Ujamaa villagization emphasized increased efficiency by the reduction of operating costs and the intensification of labor

⁷⁶ Interview, Paulo Zambe, Gallu – Ukerewe, June 28, 2006

activities. This increased efficiency was intended to accelerate production and maximize profit (Leger, 1992, p.54). Therefore, knowing the population distribution of a given territory was a key factor for administrative programs and distribution of social services.

The government made efforts to generate economic returns from the majority of the work force residing in rural areas, where officials assumed land was in abundance. These efforts were achieved by improving technologies, generating return from the majority of the work force, and by stabilizing the labor force. This reorganized production sought to decrease the porosity of the working day (Leger, 1992, p. 45). Agriculture was considered a “backbone for development” (*kilimo ndio uti wa mgongo wa maendeleo*), based upon the assumption that the majority of the population depended on agricultural activities. Hall (1974) states: “The Tanzania position as it was expressed in the Arusha Declaration, Socialism and Rural Development, the Second Five Year Development Plan and Education for Self Reliance the Desire to create a strong economy based on increased agricultural production and priority to the 95% of the population living outside the town” (p.133). The intensification of agricultural activities was undertaken concurrently with the restructure of access to health services in rural communities. Consequently, the community health workers were trained and dispatched to supervise primary health care in rural areas (Heggenhougen et al. 1987).

Those people interviewed concerning this aspect of development noted the Ujamaa villages’ goal was to facilitate economic development while improving people’s living standards. However, improvement of the people’s livelihoods would have been hard to achieve if people continued living in scattered and inaccessible settlements. One respondent echoed the purpose of Ujamaa villagization, “People were told that they

should move to the new planned settlements that were developed and accessible to social services”⁷⁷ Despite awareness campaigns, however, some people did not understand the purpose of the exercise and assumed that villagization was only an excuse for the government to take away their land and livestock and turn those into “communal properties” (*Mali ya Umma*).

The literature indicates that the villagization project was aimed at fulfilling eight objectives:

1. Establishment of self-governing communities.
2. Efficient use of rural labor.
3. Utilization of economies of scale to increase production.
4. Dissemination of new values.
5. Avoidance of exploitation.
6. Increase in living standards of peasants.
7. Mobilization of people for national defense by using villages as paramilitary organizations.
8. Facilitation of national planning (in Hyden (1980) quoting Maeda 1976, pp163-5).

Trials for the new settlements were made in a few selected villages in the late 1960s and early 1970s (1967–1972), with 20% of the Tanzanian population voluntarily resettled (Mlay, 1986). A respondent in Gallu explained the way in which the village was designed, noting that



Figure 10: Residents in front of their house, one of the eighteen houses built in Gallu-Ukerewe

⁷⁷ Interview, Esterina Namba, Kisesa, July 7, 2006

Gallu, in Ukerewe, was among the few villages selected for trials in the late 1960s. The village was designed to have 100 plots for 50 families, with each family allotted parcels of one acre (counted as 70 x 70 steps on each side). The project to build new houses in the village started in 1968; eighteen houses were built during phase-one of the project that lasted until May 1969. The government planners distributed maps with designs and locations for the construction of houses made under supervision and direction. The occupants in the village collaborated in establishing their new settlement. They supported one another by building houses in a straight line. When one house was complete, its occupants helped to build another house. The exercise continued until there were eighteen completed houses with structures shown in (Figure 10). According to respondents in Gallu, the exercise was not completed as it was planned and was ruined by greed and by supervisors who squandered resources. Other causes were also blamed for the failure of the project, such as the transfer of the Regional commissioner who prioritized the program, the recommendation of the new Regional Commissioner to suspend the building in order to emphasize agricultural activities. Families that could not get houses were given iron sheets.⁷⁸



Figure 11: Cooperative building in Gallu, Ukerewe

The government provided the village with infrastructure, experts, and farm equipment to demonstrate the newly created societies' purpose. The village owned cows

⁷⁸ Interview, Andila Makele, Gallu Ukerewe, June 28, 2006

and a poultry farm, one truck, two land lovers, two tractors, one plow, a trailer used to ferry harvested crops, a fishing boat and fishing net, a grain milling machine, restaurant, cooperative shop, and a guest house (Figure 11).⁷⁹ Trials for Ujamaa villagization were aimed studying the opportunities and challenges of resettling people, and to measure how people were responding. In addition, the trial villages were furnished with necessary services in order to portray the ideal structure of modern societies, in the hope that people would be easily convinced to resettle in Ujamaa villages.

Not all communities were provided with social services. In those that were, people praised the exercise, suggesting that the villages helped to bring people together, created social cohesion by breaking ethnic boundaries and made people feel that they were the citizens of one nation, not representatives of various ethnic groups. This experience was compared to other countries where ethnic differences have been blamed for long-lasting conflicts and clashes. Others challenged Ujamaa villagization by suggesting it was exploitative and was designed to control the poor peasantry through the bureaucratic system (Ergas, 1980).

An analysis of Ujamaa villages using people's observations and experiences also helps to examine the relationship between labor, migration, capital, industrial operations, productivity, safety, technological innovations, and the transition from colonial powers to independent government. Though not intended to directly benefit the imperialism of Western states, the Ujamaa village project had similar objectives to imperialism in the consolidation of the native labor force in order to produce goods for a centralized economy that would cater to the international market. The Ujamaa village projects were

⁷⁹ Interview, Firi Tele & Paulo Zambe, Gallu-Ukerewe, June 28, 2006

deliberate efforts on the part of the government to control the economy using what Mitchell calls the concept of “calculability.” This concept is characterized by identifying a local population, identifying the activities the population performed, identifying the social services they needed, and identifying the population’s capability to produce certain amounts of desired products, such as cash crops (Mitchell, 2002). Government reformers viewed rural settlements as ill-structured arrangements to facilitate economic growth as agricultural systems. Livestock keeping was assumed to be backwards, unscientific, and inefficient (Robbins, 2008 p.76) as well. In order to offset these limitations, intervention by experts in agriculture, livestock keeping and other programs was deemed necessary. These views provided the impetus to create cohesive communities that were calculated and standardized in terms of the population, occupied land, executed activities, required and provided social services, and produced and sold products.

In a typical Ujamaa villages situation, resettled people were given a daily work schedule for communal and individual farms. A respondent in Muliti –Ilangara, Ukerewe noted, “The resettled people worked in *mashamba ya bega bega* (literally translated as farms where people had to work shoulder to shoulder) three days a week.”⁸⁰ The exercise maximized labor potential while pushing for voluntary collaborative efforts. Meanwhile, the government encouraged people to buy goods in the cooperative shops introduced in Ujamaa villages. Centralized cooperative unions collected the shops’ products from communal farms in Ujamaa villages. The market was consolidated to funnel all resources to the central government through established cooperative shops. In other words, people

⁸⁰ Interview, Mutwa Mugeta, Muliti Ilangara Ukerewe June 27, 2006

lives were controlled on many fronts: activities they had to undertake, goods they had to buy, and days they had to work at home or in communal farms. This form of social control has unintended consequences. It creates tensions and conflicts, particularly when varied aspects of lives are streamlined to facilitated mono-economic systems. Beinart (2002) points out that “international environmental programs gave states total control over natural resources, in which cultural aspects and local communities’ engagement and rights of access are neglected” (p. 256).

Monoculture became a dominant agricultural system in Ujamaa villages executed by different ethnic groups that were brought to work together in communal farms. Under the supervision of government officials, each community in a new settlement was designated to grow a particular cash crop. People who resisted were punished through fines and imprisonment (Payer, 1983). The monoculture in Ujamaa villages was extended to health care and medical services where biomedicine was prioritized. The health care system had dispensaries, health centers, district hospital regional hospitals and finally referral hospitals. The use of traditional medicine was considered backward and was discouraged.

In other words, diversity and pluralism in therapeutic interventions were not a priority in state-controlled, modern health care systems in modern Ujamaa villages. A respondent in Mwanza noted, “Healers were seen as a group retarding development, that their presence in what was supposed to be modernized communities would have discouraged people to go to the hospitals where there was a development. That is why traditional healers were obliged to have limited role in Ujamaa villages fearing that that

they would be objecting development goals.”⁸¹ This emphasis ignored the multiple and diverse interventions that people used to respond to health challenges of both humans and livestock. However, the scattered residences that existed before Ujamaa villages had their own advantages. Because of such living arrangements before concentrating people in Ujamaa villages, Tanzania, to a large extent, escaped the epidemiological crises of communicable diseases. Despite the government’s emphasis on creating manageable communities to provide simultaneous access to social services and efficient production systems, these targets were not fully realized. Despite the government claim of victory that it was able to provide road access, to consolidate labor, and to provide social services while monitoring them (Scott, 1998), the project is portrayed as a failure (Lofchie 1978; Ergas 1980; Leonard 1980). Similar projects were introduced in Ethiopia and Mozambique; the governments undertook massive project to resettle millions of people who were considered under productive and lacking social services (Scott 1998 p.248; Lorgen 1999). Again, these governments’ approaches seemed oversimplified. Rather than recognizing people’s need and choices, and the emphasis was on quick adaptation to modernity while ignoring traditional knowledge and practices that had enabled people to survive for many years. Despite the ability of the government to manage activities, the project was not as successful as anticipated because of people’s resistance, poor implementation, and the inadequacy of prior arrangements in new settlements. Resistance emerged despite government efforts and programs that were aimed at ensuring access to social services, infrastructure, modern agricultural practices, and cooperative shops.

⁸¹ Interview, Fr. Nicodemus Salu, Bujora Sukuma Museum, Bujora-Kisesa, July 1, 2006

CONTEXTUALIZING HEALTH IN UJAMAA VILLAGES: MEDICALIZATION AND MODERNIZATION OF HEALTH SERVICES

Pluralism and and syncretism in the medical field has existed even before Ujamaa villagization (Muela et al, 2002; Heggenhougen et al 1987), as a respondent in Mwanza noted, “Hospitals existed before the establishment of Ujamaa villages, and people used both biomedicine and traditional health care services. In case one did not work, they opted for another.”⁸² However, there were very few hospitals prior to Ujamaa villages, as one of the healers interviewed in Ukerewe island (originally from Kigoma) affirms: “in our family we opted for traditional medicine, because biomedical units were few and located at far distances.”⁸³

People in rural areas, prior to the establishment of Ujamaa villages had networks of collaborations; they helped each other during times of hardship, such as taking sick people to the hospitals, which were more often located in distant places. The inadequacy of such facilities led to numerous problems, including the death of ill people, even before they reached hospitals.⁸⁴ The inadequacy of biomedical healthcare services in pre-Ujamaa forced people to continue using traditional medicine. However, some respondents noted that people in the past opted for traditional medicines due to cultural beliefs and illiteracy associating ailments with sorcery and witchcraft. A respondent in

⁸² Interview, Hena Manga, Igekemaja –Kisesa, August 21, 2006

⁸³ Interview, Bilasi Wedi, Muliti - Ukerewe, June 27, 2006

⁸⁴ Interview, Jogu Numa, Kisesa, August 1, 2006.

Mwanza for instance noted that, “witchcraft ideas dominated to the extent that even if a person was suffering from malaria, he opted for traditional medicine.”⁸⁵

Since independence, however, health issues have been formally addressed through biomedical approaches that were seen as panaceas to health and medical challenges at that time including malaria, cholera, tuberculosis, poliomyelitis (Goergen, Bruchhausen et al. 2001). The government of President Nyerere emphasized the socialist idea of access to “free healthcare service” in both rural and urban areas.

The independent government, through the support of international health and funding agencies, distributed healthcare services to the rural areas where the majority of the population resided. Experts, education, funding and the political systems were all designed to accommodate Western healthcare approaches. In recognition that the country was lacking in locally trained medical practitioners, the school of medicine at Muhimbili in Dar es Salaam was established in 1962. The government then institutionalized health programs in phases.

The Tanzanian health care programs consisted of three phases. The First Five-Year Plan (1964 -1968), according to Juntunen (2001 p.35), prioritized training of paramedical officers and the construction of health centers and dispensaries. The Second Five-Year Development Plan (1969-1974), to a large extent, embraced ideas and policies of the Arusha Declaration aimed at improving people’s living standards through access to social services. The priority during this phase was on both preventive and curative approaches to control the spread of communicable diseases (Juntunen 2001, p35). The

⁸⁵ Interview, Pasori Maga, Kisesa, August 3,2006.

government also initiated village health worker programs in the early 1970s to complement the institutionally provided health care services. Juntunen notes that the objectives of these programs were not entirely fulfilled due to inadequate supervision, lack of community support, and lack of qualified candidates for training. Yet, the government continued expanding access to health care to make such care reachable within 5 kilometers (Maro and Mlay, 1979). The Third-Year Plan (1976-1981) prioritized access to safe and clean water, access to health services in rural communities and continued training of paramedical staff (Juntunen, 2001 p.35).

These programs were implemented concurrently with the establishment of health centers and rural health institutions, training of rural staff and the medical auxiliary, and with the dispatch of mobile workers to remote areas (Van Etten and Raikes, 2005). One Priest remarked about health access services in the villages, “Dispensaries were built in some villages, but for schools, it was different. Schools were built in almost every village. There were mobile clinics that came from Sumve hospital. I can say this exercise of mobile clinics started in the late 1960s, and I am guessing this service has persisted until the 1980s.”⁸⁶

The government focused on providing health services in rural areas where the labor force was concentrated (about 95%) (Van Etten and Raikes, 2005; Sanders, 2008). The need for health services in rural areas was not merely to ensure people’s wellbeing, but also to create a capable community that was healthy and motivated to work in what was referred to as development programs, such as individual and communal farms. The

⁸⁶ Interview, Fr. Nicodemus Salu, Bujora Sukuma Museum, Bujora-Kisesa, July 1, 2006

formation of Ujamaa villages created productive engineered units that could optimize the use of limited resources with the maximized consolidated labor of healthy and efficient people.

Ujamaa villagization, as noted in the literature, brought hospitals close to people, and allowed new ideas about sanitation and health programs to emerge. Those I interviewed recognized the benefits of providing health services in rural areas. A healer recalled how he survived a scare of smallpox by the introduction of rural healthcare centers during Ujamaa villages: “I was diagnosed with smallpox at that time, but we received treatment and I recovered.⁸⁷ Smallpox spread quickly in congested areas, and I would argue that the new settlements exposed many people to the disease. However, responses from interviewees indicate that people had embraced the government information about the benefits of the villages to access to biomedical health care services.

However, despite the benefits of access to health care services in rural areas, many residents complained about health challenges and the lack of adequate health care services in newly designated Ujamaa villages. The benefits of health services offered in rural areas were overshadowed by the numerous health challenges, such as outbreaks of measles and cholera that were reported during the establishment of Ujamaa villages.⁸⁸ The Western biomedical services in the new settlements did not anticipate these side effects of population resettlement to provide access to healthcare. Some raised questions, asking why new settlements that were considered safe zones with access to social services were risky to people’s health.

⁸⁷ Interview, Neche Hango, Kanyama –Kisesa, August 1, 2006.

⁸⁸ Interview, Neche Hango, Kanyama –Kisesa, August 1, 2006

No significant efforts were made to accommodate traditional medicine as an alternative healthcare service despite the majority of the people using them. There was little or no recognition of the need to have traditional medicine operating independently or along with the field of biomedicine by the independent government in Ujamaa villages. Therefore, communities in the newly created villages faced two major challenges: an inadequacy of biomedical services and a limited application of traditional medicine.

Even so, traditional healers remained peripherally and sporadically involved in nationwide health programs. The government offered limited acknowledgment of healers after independence. The healers were allowed to practice only if they were well known and accepted in the communities in which they lived (Juntunen, 2001 p. 37-38). Despite the acknowledgement in official literature concerning the role of traditional healers in treating certain conditions (Outwater, 2001), healers' involvement in medicine remains marginal and more often challenged, because the role of healer does not include standards of practice. Standardizing traditional medicine remains a challenge for a number of reasons; among them are the diversity of practitioners and the acquisition of knowledge and skills under restrictive conditions.

Traditional healing practices are influenced by many factors: health, epidemiological conditions, economy, environmental conditions, cultural aspects and political systems. A shift of any of these factors will influence the positions of epidemiological conditions and the medical practices in any given society. Historically, healers have responded and adjusted in many different ways to the three phases of epidemiological transition: the pestilence and famine period (until 1875), receding

pandemics (1875 – 1930), and degenerative and man-made diseases (1930 to the present), (Janes 1999; Omran 1971; Rogers and Hackenberg, 1987). In responding to this latest transition, healers have continued to redefine their medical practices as they create relationships with patients as these healers collect, process, prescribe and distribute medicines. The Ujamaa villagization, for instance, shaped new ways for healers to practice medicine as they responded to the lost materials and other changes that happened during that time. Healers who feared losing land for subsistence and healing practices were ambivalent about the project; they resisted moving to the designated settlements. These healers were forcefully moved despite their resistance and those healers who were *balingi* (song composers) narrated their fear and worries about Ujamaa villagization.

RESISTING CHANGE

My study reveals that the perception of whether the villagization exercise was peaceful or coercive is characterized by peoples' decision to move to the designated settlements. Two groups emerged: one comprised people who were ready to move voluntarily to the newly designated villages and the other involved people who resisted moving. Voluntary movers saw the exercise as positive. As one of them noted, "I had no trouble during the resettlement exercise since I moved voluntarily; and trouble came for those who disobeyed the order."⁸⁹ It was President Nyerere's idea to live together for easy access of social services, a healer interviewed in Kisesa narrated, "Nyerere wanted

⁸⁹ Interview, Andila Makele, Gallu –Ukerewe, June 28, 2006

people to live together. Where we lived together we would begin to see hospitals, schools (in the past, there were no schools)”⁹⁰

Fear of unknowns and ambivalence about the new settlements made people uneasy with the idea of moving to the designated settlements. People were not confident about security in new settlements and were worried about being colonized for a second time. They feared losing personal property because of the new settlements. In a trial project in 1968 (seven years after independence), Gallu people were suspicious that they were brought together so that colonials could return and govern easily resettled people.⁹¹ The diverse groups of actors existing in pre-Ujamaa societies were not acknowledged during resettlement programs in Ujamaa villages, with the exception of the two broadly categorized groups: herders and non-herders. In recognition of these two groups, livestock owners were given extra parcels of land compared to other people (although not calculated to their exact needs). Despite this provision, interviewed herders complained that the distribution of land was not sufficient to fulfill their needs; owning a large herd of cattle became a curse of its own kind.⁹² In other words, owning livestock in the confined space of an Ujamaa village was not easy. In addition, livestock fed on and destroyed non-herder’s crops, causing tensions between farmers and livestock owners.

Healers were not prioritized during resettlement to Ujamaa villages and, instead, were categorized like other regular members of the society. Giving them additional space to accommodate their activities was not a priority in the plan for the new settlements; instead, healers were disparaged. The government’s refusal to recognize healers’ roles

⁹⁰ Interview, Neche Hango, Kanyama-Kisesa, August 1, 2006

⁹¹ Interview, Andila Makele, Gallu –Ukerewe, June 28, 2006

⁹² Interview, Jogu Numa, Kisesa, August 1, 2006

was a deliberate action, an intentional neglect of indigenous ideas, values, and practices that had sustained people for many years. The failure to acknowledge this coexistence of this tradition, along with the total rejection of healers, has delayed the development process of traditional medicines in Tanzania.

Failure to recognize the role of traditional healers and their roles in societies contradicts traditionalization efforts by Nyerere after independence. Nyerere felt that colonialism had made Tanzanians disparage their own culture and had shifted their ideologies to European ideals. At that time Nyerere's government made efforts to revive traditional cultures that were thought to have disappeared due to colonial interference. *Ngoma za asili* (traditional dances) were advocated in different institutions as a way to retain cultural values of different ethnic groups in Tanzania (Askew, 2002). However, the restriction of chiefdoms and the failure to recognize healers in Ujamaa villages' resettlements suggests there were deliberate, selective processes to promote some cultural ideas and practices that were used to empower the independent government and to discourage others so that no other groups were seen as rivals in administrative tasks. Healers and their practices did not seem to fit well with development goals or with the consolidation of power by the Nyerere government.

The independent government's goal, when creating Ujamaa villages, was to have a total control over labor to fulfill objectives to produce certain products desired by the government. The government's weakness was its failure to acknowledge the diverse groups that exist in societies. Instead, the government forced these diverse groups to function in the same way as the government-designated Ujamaa villages. People in these new settlements from diverse life styles were assumed to be capable of performing

similar, interchangeable functions (“monoculturalism.”) These diverse groups were put in the same localities under the assumption that they would be easily synchronized to adapt to a top-down governing system.

One of the emerging themes about Ujamaa villagization was the fear of losing belongings, properties and identities. People noted that they were happy with their original residence and with the materials they owned. Interviewed individuals felt that the exercise was not beneficial because many people lost their properties, were coerced to move, and were moved against their will to areas that lacked shelter, food, and water. The reoccurring themes in these discussions were complaints about the loss of land, which is not only about physical space but also about identity. Interviewed people noted that the land they owned implied a connection to identity, spirits, ancestors and neighboring communities. One respondent who is also a healer noted, “I lost my land which I inherited from my ancestors. I felt we did not benefit, but instead there was an outbreak of diseases that led to the death of many people. Famine was a problem, and people did not have shelters; there was no adequate land.”⁹³ In some situations, people associated Ujamaa with communist programs in China. Narratives from some respondents recall the magazines from China that were easily accessible at that time. These magazines propagated communalist and socialist ideology. Pictures in the magazines showed people wearing the same outfit, something that worried people in Tanzania. This fear extended to other aspects of life, included in songs composed by the leaders of Sukuma dancing groups. These songs worry that the singers’ wives will also be communal property: “After I heard that my cattle will be confined in places - “farms” (fences used to keep

⁹³ Interview, Mahele Mulo, Miaka 80, Changabe -Kisesa, June 25, 2007

livestock that were owned by the government), I was surprised, and I nodded! And I heard also our wives will be nationalized -- that is when they hurt my soul where my mind is laid.”⁹⁴ Dispossessing wives would render individuals powerless; they would be seen as too weak to hold their wives.

Such fears created resistance among groups. The government used both voluntary and coercive approaches to encourage compliance for those who resisted. The exercise of the Ujamaa village was considered necessary to improve the livelihood of the people; however, this exercise also destabilized the political identity of traditional healers in Sukumaland. Deliberate efforts were made to ensure that people were resettled in Ujamaa villages. These efforts included the use of both voluntary and coerced eviction. It was the latter that had significant impact on the field of traditional medicine. A healer interviewed in Mwanza explains the way in which healers became targets of government harassment during the establishment of Ujamaa villages:

Generally, when we were moved to Ujamaa villages, healers were very much affected. We were forced to throw medicine in the bush. I recall my grandfather was forced to throw his *Shingira*⁹⁵. Healers were jailed and punished with peppers rubbed in their genitals, and forced to answer if they were witches or not. They were tortured. They lost medicines because they were illiterate and never wrote anywhere and they threw their medicines randomly and were lost; they feared of being arrested when found with medicines. Medicines thrown in bushes and termite-hills were destroyed. The government gave us a lot of trouble in 1974, we were in turmoil and the medicine and other materials used for therapies that we inherited from our parents were lost.⁹⁶

⁹⁴ Interview Fr. Nicodemus Salu Bujora Cultural Center – Kisesa, July 1, 2006

⁹⁵ *Shingila* are referred as medicinal ingredient from plants, animals and minerals that are known to influence potency of medicine in terms of protection, aggressiveness, vitality, and love-philter (Cory 1949, Bassire, 2009)

⁹⁶ Interview, Mubi Makemo Kanyerere-Misungwi, September 3, 2009.

Despite sporadic efforts by the government to recognize traditional medicine in the Medical Practitioners and Dentists Ordinance of 1968,⁹⁷ the Ujamaa villages in the 1970s changed many of the structures that governed health and medical practices for the Sukuma people.

VOLUNTARY VS. COERCIVE MIGRATION AND CULTURES OF LAMENTATION

The government government believed its own campaigns and propaganda; people would move voluntarily into new designated places. However, some people were ambivalent and, among them, those who resisted moving to Ujamaa villages were forcefully evicted from their houses and their houses were burned and demolished.⁹⁸ People were concerned with the unknown, with the newness of the settlements. They were concerned about the security of their lives and properties because information about security in the new settlements was not available to them.⁹⁹ People who were interviewed noted that some were reluctant to move to new places, and that this reluctance forced the government to use coercive approaches. McGee (2008) echoes this argument, suggesting that moving to Ujamaa villages was no longer voluntary; forced villagization had begun. By the late 1970s, 80% of the Tanzanian population of Tanzania had been resettled in Ujamaa villages, both voluntarily and coercively (Shao, 1986)

⁹⁷ The role of traditional medicine in political system covered by Gloria Waite (1987) *Public Health in Pre-Colonial East-Central Africa Sot. Sci. Med. Vol. 24. No. 3, pp. 197-208, 1987*

⁹⁸ Interview, Mubi Makemo, Kanyerere-Misungwi, September 3, 2009.

⁹⁹ Interview, Musa Ng'wana Nyanda Mandula, Igekemaja-Kisesa, August 21, 2006

People have challenged the approach that was used by the government to settle people, suggesting that there was no adequate preparation in new settlements to accommodate resettled groups. In addition, compensations were not made to repay the damage and loss of property during the exercise, as there was no account of material loss. In some circumstances, peoples' land and crops were dispossessed or left unattended. Security assurance is important among the Sukuma people and they use both individual and personal protection mechanisms. One of the protective aspects that Sukuma people embrace is to secure the places where they want to live or do business by using *nkhago* (protective medicine). Wa-Sukuma desire for protective medicine among could not be met during villagization because this focus could have been associated with the acceptance of witchcraft ideas at a time when these ideas were being discouraged. This inability to use protective medicine gave impetus to some forms of resistance to move voluntarily, particularly for healers, livestock keepers, and farmers.

Forcing people to move to new places without acknowledging their sense of place and modes of security was to deny them confidence about new residence they had to occupy. Tensions emerged on multiple fronts, particularly when disposed land was given to other appropriators in Ujamaa villages. First, hosts were not happy about the new occupants of their lands. Second, people were not happy with the government decision, the discourse that has characterized the negativity of the exercise. People argued that supervisors were not concerned about people's lives, but rather their concern was to impress their masters, even if the exercise was not going well.¹⁰⁰ I argue also that failure

¹⁰⁰ Interview, Nhumbu Bumila, Kisesa Mwanza, July 22, 2007

to protect new places using *nkhago* (protective medicine) among resettled inhabitants created security concerns and propagated fear and ideas of witchcraft.

The villagization process yielded unintended social consequences particularly when force was used to move resisting individuals. People who resisted moving in many cases had their homes demolished (Mlay 1986) and properties lost the condition that further aggravated negative opinion about villagization. Para-military groups enforced orders from the government to live in designated villages. In addition, people who resisted were assessed financial penalties (Mlay 1986). Houses were destroyed, crops were burned, roofs were ripped off, houses were bulldozed and people were packed into military trucks and released in open spaces - harsh environments with extreme weather and wild animals. Villagization also often brought people to live together in places that lacked efficient health infrastructure.

The opponents of the Ujamaa exercise expressed different arguments. The project was rushed and poorly implemented. Local conditions were not studied in order to predict the outcomes of the new settlements. Furthermore, people were not consulted to gather opinions on what Ujamaa villages should look like; rather, they were asked to resettle in newly designated places according to officials' plans. Some respondents had different opinions. They argued that the failure to attain desired goals of Ujamaa villagization was a result of poor implementation by the individuals mandated to supervise implementation of the project. As one of them noted, the exercise was implemented upon the people who were illiterate and who did not understand the aims of the exercise. This failure to

communicate was the major reason for the problems experienced in different places, and this failure caused different problems that were reported in different places.¹⁰¹

The Ujamaa village program created a number of problems for healers and consumers of traditional medicine. Healers were disoriented, discriminated against and denigrated for their practices. Their knowledge was disparaged and deemed backward and unable to advance health development in the new Ujamaa village settlements. They were evicted coercively from their residences. This condition led to the loss of different kinds of materials used in therapeutic processes. Healers in Ujamaa villages were challenged and accused of resisting development or retarding the development processes by maintaining their traditional systems. They were identified as the group that embraced backward ideas. The presence of healers in Ujamaa villages was seen as an obstacle to the intended objective of “modern” healthcare services.

LOSSES EXPERIENCED DUE TO UJAMAA VILLAGIZATION

MEDICAL PARAPHERNALIA

In the process of forcible relocation, healers’ materials and therapeutic paraphernalia were lost, destroyed, or burned. In addition, the conditions in the new settlements did not lend themselves to the needs of healers’ activities, compared to the residences that healers occupied over the years in *mahame*. A healer who inherited medical knowledge from his father noted, “There was not enough time to move to new places. We just suddenly saw trucks coming and started destroying houses; destroying

¹⁰¹ Interview, Jogu Numa, Kisesa, August 1, 2006

them; burning them; and tearing them down. We had four houses, and we lost many things. My father lost the horn in which he kept his medicine. Our houses were burned because my father refused to move, and his lion skin was also burned. He cried for the loss of it.”¹⁰²

The coercive evictions and their subsequent impacts during resettlement are conspicuous in the narratives made by healers and by *balingi* (song composers and leaders for Sukuma dancing groups who are often healers) through songs and tales. These songs and tales are the modes that Sukuma people use to express their opinions about events. Some of the songs have been captured by Gunderson (2010) and show different features of the Ujamaa villages. Such songs include those in praise of Nyerere; other songs question the benefits of Ujamaa villages (p.356-361). An example of this song resistance comes from Nhumbu Bumila, a famous healer and a *Ningi*. A *Ningi* is a poet/singer/dancer and leader who, in modern times, would be called a rapper. *Balingi* (a plural for *ningi*) pick statements of events and elaborate on them in songs or poems to entertain people for a *Bagalu* (a popular dancing group in Sukumaland.) In an interview, Nhimbili explained the way in which the Ujamaa exercise caused the loss of *shingila*. He recalled one of the songs composed by Ile Kasala, Nhumbu’s predecessor, teacher, and leader of a dancing group. Kasala abandoned traditional medicine practice due to the loss of his medicinal materials and because of the way in which traditional medicine came to be perceived (in the song he refers himself as son of Kala Ngosha Gunila).

¹⁰² Interview, Nече Hango, Kanyama-Kisesa, August 1, 2006 , Kanyama-Kisesa, August 1, 2006

I have lost my *shingila* during Ujamaa villagization

I do not have anything left, my children

I have lost my *shingila* during Ujamaa villagization

I do not have it anything left, my children

When *ikei-kei* (chaos erupted), it was about hiding *mitumba*¹⁰³

I do not have it anything left, my children

When chaos erupted, it was about hiding *mitumba*

I do not have it anything left, my children

I cry – the son of Kabula Ngosha Magunila ooh my mother!

I cry – the son of Kabula Ngosha Magunila ooh my mother!

They have destroyed me; I have lost my *shingila* during Ujamaa villages.

The song reveals the chaotic situation during Ujamaa villagization when healers made efforts to hide their medicine without success. People were restless and confused. Kasasala laments he has nothing left. His awareness that his children will inherit his loss destroys him. He cries for his mother's help. He refers to *ikei-kei* as the moment of unbearable climactic chaos as people were coercively moved. Mzee Nhimbili noted Idele Kasasala's song remains popular to this day. He continued, explaining, "The exercise had no mercy, it caused chaos to people's property and activities, and people were confused and restless. I had *shingila* to mix in my medicine; I do not have it anymore to give it to

¹⁰³ *Mitumba* referred as storage facilities for medicines such as gourd.

my children, because during the exercise my children kept dropping it when going to hide in sisal plantations.”¹⁰⁴

Healers became victims of coercive acts by the government. They accepted the situation while lamenting the future of traditional medicines and the fate of their children who would lack medicines to inherit. The disturbance experienced by healers during Ujamaa villagization parallels the disturbance experienced by Nuer Prophets of the southern Sudan. Writing of Nuer Prophets, Johnson notes that Nuer prophets were very much disoriented by the British Colonial rule, while others were killed. But the remaining prophets readjusted their traditions and ideals to fit into the new emerging political environment and religions such as Christianity (Johnson, 1997).

Other researchers who conducted fieldwork in Sukumaland recorded the loss of medical paraphernalia. In one instance, Bessire (2000) noted the impact of Ujamaa villagization on a famous healer named Shilinde Mungu wa Pili. Bessire notes that Shilinde lost almost every medical material *shitongelejo*,¹⁰⁵ the objects of ancestral remembrance inherited from his mother. These materials were burned during a resettlement program in 1970s when people were requested to move to Ujamaa villages.¹⁰⁶

When asked what happened to the healers, especially when they were not able to recover their *shingila*, Nhumbu Bumila noted that Ng’wana Kabula Ngosha Magunila,

¹⁰⁴ Interview and Song, Nhumbu Bumila, Kisesa, July 22-24, 2007)

¹⁰⁵ *Shitongelejo* according to Wiljsen (2000) are the personal belongings of the ancestors in “Popular Christianity in East Africa: Inculturation or Syncretism?”; Stroken (2008) calls “what has preceded” such as inherited bracelets in Tanzania’s “new generation”: the power and tragedy of a concept.

¹⁰⁶ Source by Mark Bessire at <http://philip.greenspun.com/sukuma/shilinde.html> retrieved on December 28, 2010

another healer and a leader, abandoned his medical practices but continued his work a *Ningi*, (a composer and lead individual in his Bagalu dancing group).¹⁰⁷ Nhumbu Bulima himself remembers that he also lost important medical materials that were important in preparing therapies. The *kei-kei* (chaos during resettlement to Ujamaa villages) had destroyed everything. He related how resettlement had changed the therapeutic process in the contemporary settings with this narrative:

Some ingredients used in medical practices were destroyed, because healers were forced to throw them away. No one had experienced that kind of event, not even our parents or our ancestors. Healers who were composers of songs were obliged to compose songs that explained the impact. Many medical paraphernalia were lost and healers were forced to move to new places. Places that healers tried to hide their materials (in the bush) were invaded by the herders and the materials destroyed by livestock or taken by these herders. It was a loss, and getting them today is not easy, and others cannot be found nor obtained today. However, some can be purchased. Thus, if it happens that a patient or client come to me and wants the medicine that had to be mixed with the materials I lost, I tell them to go and buy them. These materials are expensive now costing about 10,000 [Tanzanian shillings (TSH.)], but if they bring them, we can make the medicine and also use the remaining portions to prepare medicine for other clients.”¹⁰⁸

Another interviewed healer had a different opinion about the ways in which lost materials were recovered, noting, “Healers who lost their paraphernalia acquired new materials through guidance by the ancestral spirits.”¹⁰⁹

These quotes indicate that the loss of medicinal paraphernalia was inevitable; however, healers responded by either abandoning the practice of their medicine or by changing their mode of practice. The potential risks linked to the loss of materials used by healers during Ujamaa villages period raised other important ethical issues. For

¹⁰⁷ Interview, Nhumbu Bumila July 22, 2007 also in Bassire (2000)

¹⁰⁸ Interview, Nhumbu Bumila, Kisesa-Magu, July 22, 2007

¹⁰⁹ Interview, Mubi Makemo, Kanyerere, September 3, 2009

instance, what do healers do when equipment and paraphernalia necessary for therapeutic processes are lost? How do they cope in such circumstances? It is true that some healers completely abandoned their activities following the loss of materials and the disturbances accrued during the Ujamaa villages period? Do healers willingly inform their clients about the loss of materials considered necessary for therapeutic purposes? If so, are they willing to recommend that their customers consult Western medical practitioners? It is a matter of choice for healers to offer therapies that they genuinely believe to be right, instead of administering something with which they can earn money without concern for the fate of their clients. Furthermore, dealing with the ethical issue underlying the field of traditional medicine, as opposed to its administration, presents challenges. For instance, how can one test traditional medicine? What standards are appropriate to justify the genuineness of traditional medicine? These questions have lingered in the field of traditional medicine for years.

THERAPEUTIC LANDSCAPE AND THE BUILT ENVIRONMENT

Healers interact with the environment on a regular basis in their search for medicinal flora and fauna. In addition, healers are more likely to be involved in other activities that are linked to the environment, such as agriculture and livestock keeping. These conditions make healers an important group to study in order to understand how the shift in landscape influences new ideas of medical practices. Healers are actors who know their fields, forests, and streams, and who, through observation, learn and transmit the history and myths of their ethnic group (Dubos 1968).

Healers, like any other health practitioner, operate in a space called the therapeutic landscape, an efficient area that is suitable to practice medicine based on healers' choices. The therapeutic landscape involves natural conditions and human modifications that enable healers to practice medicine, as well as a geographic space for clients (patients) to access medicine. Traditional healers depend on the quality of the environment to secure medicinal flora, fauna, and minerals needed for therapies.

The fieldwork in Mwanza suggests that healers are more likely to prefer to choose a place to operate rather than have a place chosen for them. However, this approach is not without tension, especially recently, when most of the land in both rural and urban areas is already occupied. During Ujamaa villagization, healers, like many other members of the community, were forced to obey the orders of the government to move to designated places. Healers had little choice about the features of their own medical landscape; villagization altered the sense of the medical landscape. Healers lost confidence in their ability to own land for farming, and to develop their residence to accommodate medical practices. Previously, healers planted and maintained trees in *mahame* knowing that these plants belonged to them; in Ujamaa villages, people lost that sense of ownership.”¹¹⁰

The way in which events unfolded during the Ujamaa villages relocations suggests that the medical landscape for healers was not a priority for government supervisors and provides another example of the way in which healers' activities were not acknowledged. When considering the medical landscape, Williams (1998) observed that it is a human's consciousness, through critical analysis of options, which allows for

¹¹⁰ Interview, Wilson Solonda, Kisesa-Magu, August 1, 2006

the selection and creation of therapeutic landscapes. These landscapes include policies, institutions, economics, social structures, social identities and politics that impede or facilitate the way in which individuals create meaning of specific geographical space (Williams, 1998). They also determine meaning in illness, access to healthcare in a particular landscape. A healer's site selection is based on access to areas where healers may perform rituals and on access to locations where they can easily access medicinal flora and fauna.

Healers identify and create "the built environment," whether natural or artificial, that is suitable for their therapeutic activities (Bridgman, 1999). This built environment is chosen and designed based upon healer's historical knowledge, ancestral connection, learned ideas, socioeconomic activities, access to customers, and interests. A retired teacher who has worked in various places in Mwanza summarizes what he felt were the impacts to the traditional healers due to Ujamaa villages:

I feel it was a disturbance, because for traditional healers who are settled (sedentary) in a particular place, are more likely to possess materials useful for their therapeutic activities. This could be treating rooms (wards). The Ujamaa villagization exercise forced healers to move to new places, more often had to build small houses. Clients who were familiar to the healers' residence initially started wondering where they could locate their healers. They (healers) were very much disturbed and since then they have been affected, because they had their spirits guiding them and they performed rituals in those original places. They had their clients who visited them into original places and could not find them (healers) when Ujamaa villages were introduced.¹¹¹

For traditional healers, both the medical landscapes and the built environment are subsets of the natural environment. Both are major determinants of traditional medicine, and both determine whether their therapies are local or indigenous. Anyinam echoed this

¹¹¹ Interview, Wilson Solonda, Kisesa, August 1, 2006

argument (1995) in the observation that traditional medicine depends on biotic and abiotic environments, and natural features with religious significance to local people and practitioners of ethno-medicine. The selection of places to practice medicine has to acknowledge the magico-spiritual and religious aspects of ethno-medicine (Anyinam, 1995). In many indigenous societies where the practice of ethno-medicine is predominant, local people assign sanctity to certain portions of their natural landscape and regard them as worthy of devotion, loyalty, dignity and worship.

Williams (1998), quoting Kleinman, indicates that “a medical system is an ordered, coherent body of ideas, values, and practices embedded in a given cultural context from which it derives its signification. It is an important part of the cultural world and as such it is contracted, like any other segment of social reality, by a remnant body of symbolic meaning” (Kleinman, 1973, p.208). Another important feature for the therapeutic landscape is the “sense of place.” Sense of place encompasses identity, significance, meaning, intention, and felt values that are given to places by individuals. As a result of this experience, over time, “places provide meaning for people in many different ways: through identity and feelings of security, as settings for family life and employment, as locales for aesthetic experience.” (Williams (1998) quoting Gesler, 1992). In other words, sense of place provides assurance and satisfaction to healers when operating within a chosen location.

Traditional healers rely on a variety of herbs, roots, leaves, tree bark and a wide variety of animal parts (many of which are from endangered species) to prepare their portions and remedies (Warchol et al, 2003). The stability of healers’ medical practices is influenced by the stability of environmental niches, particularly when dealing with

endemic ailments. However, there is no such stability when political, ecological, cultural, and socioeconomic systems are continuously changing. Therefore, healers, just like biomedical practitioners, must rely on their ability to adapt to changes that are occurring in a society, particularly when they have to deal with new diseases within a different environment, where sites to collect medicine are also new. In addition, healers must engage new clients who speak different languages.

The migration of healers to the new settlements – Ujamaa villages – created conditions in which healers constructed new meaning, beliefs and practices of their therapies in relation to the new landscape. Forced displacement created new meanings in the health and medical practices offered by traditional healers. Charnley (1997) refers to environmentally displaced people as a group of individuals forced to relocate due to local conditions which may include a lack of natural resources, droughts, floods, and other natural disasters. She notes that migrant groups often have to encounter and overcome land disputes with the local communities. The level of tension in these conflicts over land may be reduced or aggravated depending on the existing political structure of land management and other social conditions existing in a particular society. In addition, migrants are more likely to blend or lose their traditional values after establishment in new areas.

I argue that the resettlement created tension between inhabitants and migrants and is seen in Mwanza through the competition among groups of healers. This competition is characterized by the way in which knowledge of the environment is translated into a power struggle over medicinal knowledge. Traditional medicine, embedded in culture, is influenced by the conditions encountered in new settlements as well as through the

process of migrating itself, whether migration is voluntary or forced. Healers are like any other group of actors but are differentiated from other groups by their knowledge of the environment in relation to medicinal resources. This knowledge makes healers more likely to feel the impact of change. Migrating peoples, including healers, lose their local knowledge of the environment with which they had become acquainted in their native lands – knowledge for resource use and management. When people move to a new environment and adopt new economic practices, they may not be highly informed and skilled in their new surroundings at the outset (Charnley, 1997).

The Ujamaa Villages Registration Designation and Administration Act of 1975 was intended to pave the way for every village to become a multipurpose cooperative society (Moore, 1979). Although the Act did not contain provisions on land tenure, such provisions were included in subsidiary legislation.¹¹² The village councils allocated farmland to households according to their needs and their ability to develop those lands. The village councils of the Ujamaa villages were required to acquire rights of occupancy to land within the limits of each village. No other person had any right, title or interest in or over any land within such limits,¹¹³ extinguishing customary tenure. Before independence there were four categories of land tenure in Tanzania including freehold, leasehold granted by the Germany colonial power, granted right of occupancy, and deemed right of occupancy (Mlay, 1986). Mlay further notes that granted and deemed rights of occupancy covered about 95 per cent of all peasant land holdings. These holdings were based on customary land laws of sale, pledge, inheritance, wills and

¹¹² Act No 21 of 1975 GN No 168/1975

¹¹³ Under Directive 9(2)

leasing. However, in 1963 all these tenures were abolished and freehold tenures were converted into 99-year leases. The Ujamaa Villages Act No.21 of 1975 contains a provision stipulating that planning area lands be granted to the Ujamaa villages for cooperative and communal development programs (Mlay, 1986). As a result, even the relocation of peasants during Ujamaa villgization caused land tenure confusion and numerous disputes. Peasants whose land had been taken and given to other peasants sued in courts of law for the restoration of those lands.

Although the act stipulates that the allocation of land be based on needs and ability to develop it, the fieldwork suggests that the distribution of land was uniform for the residences and farms. The only distinction was in the distribution of land was for livestock keepers who were given extra land to accommodate their needs. A healer operating in Iseni-Kisesa noted that in villages before Ujamaa villages healers had plenty and convenient space to practice medicine.¹¹⁴ The consideration of extra land for healers to develop to practice their work was ignored. The need for extra land became one of the salient features in new settlements. This need was echoed in people's expressed interests to retain their original land in *mahame* for various reasons, including spiritual connections to their ancestors, connection to the environment in which their ancestors had lived, and connection to familiar farmlands on which they had grown food for many years. A healers operating in Ukerewe reveals how his parents were able to acquire land in Ujamaa villages and also retain their land in *mahame*. "We had plots in both sites in a village that we moved in, and in *mahame*. Later my parents decided to go back to *mahame* in areas that were not occupied by the military to establish a military camp.

¹¹⁴ Interview, Seleta Kadulu, Kisesa Magu, June 20, 2006

However, we were compensated for the areas that were taken by the army.”¹¹⁵ The need to have extra land in new settlements while retaining original lands in *mahame* created a number of problems, as noted in the Presidential Land Commission Report.¹¹⁶ The report further indicates that the villagization exercise was negatively impacted by fraud and greed. Excessive land was given to leaders’ relatives; other members of the community were denied equal distribution (p. 51).

The commission recorded that land ownership was not clearly defined. Land disputes were common because many people experienced situations of encroachment, invasions and sometimes favoritism toward particular individuals in regard to land rights (p.59). Consequently, in the 1980s the courts recorded a substantial number of lawsuits related to land disputes. This was also the time when people began to return to their original lands. Some have argued that the problem was mainly caused by a lack of clear guidelines to establish legal rights for land. Conflicts also emerged between the state and the people regarding customary laws about territorial control of land and other property when dealing with land disputes.

Land ownership created tensions and conflicts that were further translated into crimes, witchcraft accusations, and violence. Respondents from different villages noted that some groups of people were resettled on the occupied land. Hosts had to relinquish part of their lands to these migrants. The process of relinquishing land was not received positively; this complicated the relationships between hosts and newcomers. The problems experienced in Ujamaa villages motivated other people to return to their

¹¹⁵ Interview, Biswe Swedila, Muliti, Ilangara – Ukerewe June 27, 2006

¹¹⁶ Source “The United Republic of Tanzania (1995) Report of the President Commission of Inquiry into Land Matters. Volume 1: Land Policy and Land Tenure Structure

original lands (*mahame*), a situation that had double impact: 1) reduction of pressure on the land in the new settlements where people were concentrated and 2) recovery and provision of security to the land and farms left as *mahame*. However, not all who returned to the *mahame* were able to secure their property. A few who returned to their original lands managed to secure their *mahame*. As one respondent noted, “In my farm twelve people were brought during Ujamaa villagization; I retained my land after people started going back to their land (*mahame*).¹¹⁷ Wiljsen and Turner (2002) note that, despite deliberate efforts by the government to break the social structure in Sukuma of well-dispersed hamlets by creating Ujamaa villages, people started returning to their previous way of living as soon as the political enforcement was abolished (p.35). But not all *mahame* were empty. Some were occupied, as noted by the tensions recorded in the *mahame* between old and new owners of the land at the time of Ujamaa villagization (The United Republic of Tanzania, 1995 p.54). These tensions were translated further into witchcraft accusation and in attacks upon people said to be witches.

A lack of privacy compromised traditional healing practices in Ujamaa villages. According to Bassire (2000) healers’ pre-Ujamaa compounds were traditionally designed to be out-of-sight to others by fences made of *minyaa* (*Euphorbia tirucalli* Linn.) Likewise, privacy for healers remained a key aspect in their therapeutic activities. Healers, like doctors and nurses in biomedical units, are aware of the need for privacy for their customers. Likewise, to a large extent, healers secured their sites to give an assurance of privacy to their customers. The privacy and security issues were a concern

¹¹⁷ Interview, Nyanga Mangala, Igekemaja, August 21, 2006.

for the healers in the new settlements. Residences for Sukuma healers, according to Bassire, are built with privacy and security consideration. Healers used *minyaa* (plural for *mnyaa*) for fencing as physical protection of the interior because of the toxicity of its stinging, milky white liquid that repels reptiles and minimizes cattle raids (Bassire, 2000 p.88). The *mnyaa* plant has other functions in the field of traditional medicine, including divination, protection and healing. Thus, Ujamaa villagization disrupted security measures used by healers. Privacy for healers was also compromised in the new locations. In addition, their available time to attend to clients was affected by the by the compulsory communal activities instituted in Ujamaa villages.

The Ujamaa villagization affected other aspects necessary for healers' therapeutic landscapes and the built environment. Healers noted that it was difficult to build ancestral shrines (*numba ja masamva*) and wards necessary to accommodate patients and their relatives. Bassire (2000 p.102) notes, "The shrines are still the site of sacred memory; they are still utilized to honor the ancestors. *Bafumu*, however, who rely on a positive relation with their ancestors, build shrines as an ongoing memorial site. They additionally honor their *masamva* (ancestors) through their construction of space in the compound and by their use of objects."

Healers developed built environments featuring shelters for used for different activities, including wards, waiting rooms, and divination places. Healers in Ujamaa villages faced challenges in designing these features because the government did not include healers' opinions about the size and location of various environments when creating the new settlements. As a consequence, the parcels of distributed land in Ujamaa villages restricted healers' activities in many different ways. The privacy of healers'

activities was compromised because the small spaces did not allow for the construction of shelters that could accommodate different activities related to therapeutic work, such as wards and ancestral shrines.

Healers in the rural areas were known to establish their residence in open spaces, particularly in places near shrubs or forest (Figure 12). Finding such environments, according to healers

interviewed, was a challenge in new villages because of the small-sized



parcels of land that

Figure 12: Healer's residence in rural area

they were given, and because of the negative attitude among government officials regarding building environments for healing activities in Ujamaa villages. Healers themselves feared that they were introducing something that was considered primitive in an environment that was intended for modernity where emphasis was on the services offered by biomedical interventions.

LIVELIHOOD AND FAMILY-HOOD

Traditional healers' modes of operations encompass the physical and societal conditions, as each influences the other. Good physical condition relies upon healthy societal conditions, which are, in turn, determined by the physical well-being of the people. Therefore, apart from knowledge that healers possess, they also value property that they own, such as land and livestock. Land is as important as medical knowledge

among Sukuma healers. Diseases are created through interaction with land, but interaction with land also creates therapies of different kinds. Land creates conditions for agricultural production, livestock keeping, access to medicinal materials, and places for rituals. All these interactions with land are important for the therapeutic process. The importance of land and the hand-hoe among Sukuma people resulted in the popular saying, *Igembe sabo* (a hoe is a treasure). Bassire (2000 p.49) and Gunderson (2010, p.288) cover the importance of a hoe in Sukuma rituals and agricultural activities. A respondent in Kisesa explained how social relations have changed in communities, “People are nowadays canny, in the past before Ujamaa villages people were able to invite other community members in a systems called *buyobe* that people will come and help you in your work such as farming or harvesting, and what you ought to do was just preparing food for them. They never demanded money after the work but now it is just money!”¹¹⁸

The majority of the interviewed traditional healers had farms that created food supplies, not only for the family members, but also for patients and their therapeutic management groups. Farms owned by healers had other symbolic relationship in therapeutic activities as well. For instance, farms served as sites where labor from a healer’s clients was applied to pay for therapeutic services. Therefore, some patients or therapeutic management groups paid their fees by participating in production activities, particularly on the farms owned by healers. This kind of interchange still exists today, but has declined. Healers were confident that having patients was a form of power and fame

¹¹⁸ Interview, Jogu Numa Kisesa, August 1, 2006

in the community, especially when patients recovered. A healer respondent recalled his father, a healer who was compensated with cows for therapies he offered before Ujamaa villagization. Clients brought goats that were used for therapies; female patients brought female goats and male patients brought male goats. The situation has changed with an increase in diseases. Monetary compensation now dominates. With the increase in epidemics and incurable diseases, people are willing to pay TSH. 100,000 (equivalent to \$ 75) for treatment. In the past, healers offered free treatment to some patients.¹¹⁹

Popular healers attracted many clients who became another source of labor for both domestic and farm activities and thus provided positive feedback for healers to increase the power and fame through their accumulated wealth and ability to work with many people. In order to facilitate this positive feedback, healers used attraction charms to gain more clients.¹²⁰ This form of power relations between healers and clients was not acceptable to the government for the realization of Ujamaa villages because it contradicted the ideology and purpose of villagization to restrict the exploitation of one man by another man. Under this ideology, healers' clients who worked off payment on healers' farms appeared to be a form of labor exploitation. Governing authorities critiqued this arrangement as *ukabaila* (capitalism) and *ubwanyenye* (bourgeois). This critique, however, ignores and contradicts forms of kinship developed between healers' and clients' families. Such kinships formed a sort of "family-hood," one of the main pillars for the establishment of Ujamaa villages. The main differences between the villages view and the healers' are the forms of exchange and the gains obtained by the

¹¹⁹ Interview Neche Hango, Kanyama-Magu, August 1, 2006.

¹²⁰ Interview, Nhumbu Bumila, Kisesa-Magu, July 22, 2007.

involved parties. In Ujamaa villages, for instance, people were asked to work in communal farms and to buy products sold in cooperative shops. In contrast, labor exchange between healers and their clients had a direct benefit to the healers, depending on the amount of crops produced. In addition, clients of therapies were assured that they could receive treatment even though they lacked financial resources.

This labor-compensation became a form of insurance and assurance of its own kind to the healers as well as to their clients. Clients or patients were aware that, even though they might not have enough financial resources to pay for the therapies they received, they could negotiate compensation through bartering their labor. In most cases these negotiations were by mutual agreement and allowed for win-win situations. Healers offered treatment and clients reciprocally offered their labor. Patients were not the only ones who offered labor; it also came from patients' support-groups, comprised of family members and friends. The agreement was undertaken with mutual understanding and respect. In other words, regardless of a client's capacity to pay for treatment with money, these clients received treatment. Discussions with healers about the mode of compensation revealed that healers were often not worried about their patients' ability to pay.

Healers were convinced that they supported patients; they expected the same recognition from their clients regarding aspects of compensation. In the contemporary setting however, money exchange has become a major form of compensation, and healers indicated that financial compensation from their clients is important for them to survive in the business and be able to provide services efficiently. This is why a majority of the healers would ask for *kisimba miti* (payment in the amount of TSH. 10,000 to enable a

healer to start the process of finding medicine) for new clients. Despite the importance of *kisimba miti*, healers acknowledged that they have treated many people who have disappeared without paying.

Healers' support mechanisms for their clients and apprentices were compromised in many different ways in Ujamaa villages. Land that they received via the villagization process was not adequate to produce enough food. Healers' available land was reduced and, thus, the need for labor from clients who also supported production activities by barter payment was also reduced. In addition, new site allocation for healers was not necessarily productive, and this allocation occurred while previously owned farms were left unattended, allowing wildlife and birds to damage some crops. According to Robbins (2008), about 60% of the new villages were built on semiarid land that required long walks to reach farm lots. Many respondents contacted during my fieldwork support Robbins argument. Peasants were removed from fertile farmlands to poor lands or land whose soil was unsuitable for growing crops. Their labor and way of farming were also changed, and this meant that villages were located at a distance from crops and this distance left the crops vulnerable to theft and pests (Robbins, 2008).

Interviewed healers noted that reaching farms in *mahame* was not easy. These farms were far from places where healers were relocated. One healer summarized the impact the experience of farming corps in the new villages. "We were not able to access our farms easily, because they were very far, we were not able to get there on time. When you grow crops, they were destroyed by wild animals because nobody was there to

provide security.”¹²¹ Problems were not only confined to the original farms. Another healer in Ukerewe Island notes, “In the newly established settlements, livestock intruded on farms, feeding on and destroying crops. These conditions created conflicts and lawsuits particularly when there was disagreement about the compensations”¹²²

Healers could not afford to host many clients in newly created settlements for a number of reasons. When land was allocated, the presence of healers’ clients (patients admitted at healers’ residences including therapeutic managing groups) was not taken into account. This healer-client interaction in traditional medicine was never acknowledged in the process of land distribution. Healers’ activities were not prioritized when land was distributed and the suggestion that healers’ activities needed more space in a way analogous to a herdsmen’s greater need was not taken into account. On the contrary, healers, like other community members, lost their farmlands. This loss of land meant reduced capacity to house clients, reduced ability to own livestock, compromised security issues, and reduced time to deal with clients, as healers had to spare time to work in the Ujamaa villages’ communal farms.

LAMENTING ABOUT HEALTH CRISIS AND DEATHS

People were confused by the health situation in Ujamaa villages because the incorporation of the health programs in Ujamaa villages did not provide immediate results. Barry and Frank (1986) note that the commitment to provide comprehensive

¹²¹ Interview, Tomaka Misu, Iseni changambe, June 23, 2007.

¹²² Interview, Biswe Swedila, Muliti - Ukerewe, June 27, 2006

preventive and curative healthcare to a predominantly rural population was constrained by economic adversity, by legacies of colonial medicine, and by widespread drug shortages. Newly created settlements lacked adequate health facilities to accommodate the immediate needs for the health challenges encountered in new settlements. Health planners might not have foreseen the adverse health impacts of moving large masses of people to the new areas. Consequently, outbreaks of disease and death occurred frequently. “We were congested in designated settlements, consequently there were outbreaks of communicable diseases, and at some point we did not get water.”¹²³ Both my interviews and the literature indicate the outbreak of diseases such as cholera, typhoid, pneumonia and diarrhea in Ujamaa villages (Coulson 1982; Lorgen, 1999). The interviewed respondents noted that outbreaks of diseases were mainly caused by congestion, poor sanitation and a lack of toilets.¹²⁴ These outbreaks occurred despite sporadic interventions widely broadcasted by national radio programs and local newspapers, using slogans such as *Mtu ni Afya* (“Man is Health”) (Mbuda, 1977; Hall, 1975 & 1978).

The spread of disease was contrary to the idea of Ujamaa villages, which emphasized the need for improved living standards in an effort to reduce mortality and morbidity rates. The opponents of the project have highlighted the outbreaks of disease and reported deaths as one of the arguments challenging the viability of Ujamaa villages (Kjekshus, 1977). People questioned why moving into new areas that were advertised as

¹²³ Interview, Alonce Manga, Changambe - Kisesa, June 19, 2007.

¹²⁴ Interview, Biswe Swedila, Muliti- Ukerewe, June 27, 2006.

safe was making many people sick or dead. Respondents noted that this experience was different than the experience in their old communities¹²⁵

Most respondents in my study noted that blame should not be on the idea of the villagization; instead, respondents say supervisors failed to plan and execute the project systematically, effectively, and efficiently. This failure to achieve the intended outcomes in the Ujamaa villages is blamed on the weakness of the individuals tasked to supervise the project, as well as the enormity of the task in question (Scott, 1998). Critics blame supervisors for not fully understanding the objectives of Ujamaa villages. Supervisors did not know how to organize people to respond to health challenges in new settlements in these critics' view. Supervisors often performed tasks to please their superiors, rather than account for local needs. In reference to this situation, one respondent in Mwanza noted, "It was Nyerere alone who had a vision of Ujamaa villagization, others were just implementing orders."¹²⁶ Another responded echoed, "It was Nyerere's idea that people should have access to social services, but it was hard to determine what the thoughts of other leaders were."¹²⁷ Other respondents noted that the exercise was ambitious and that the country was ill prepared to move people over a short period of time in the way it was done. Consequently, the new places were not livable; they lacked shelters and important services.

Poor housing, famine, a lack of sanitation infrastructure, and safe and clean water aggravated the epidemiological problems leading to deaths in the new settlements. These poor conditions increased the transmission of communicable diseases such as pneumonia,

¹²⁵ Interview, Neche Hango, Kanyama-Magu, August 1, 2006.

¹²⁶ Interview, Fr. Nicodemus Salu Bujora Sukuma Museum, Bujora-Kisesa, July 1, 2006.

¹²⁷ Interview, Gamella Lugasha, Kisesa-Magu, July 5, 2006.

meningitis, tick-borne diseases (caused by people living together with animals), small pox, measles (*isela*), meningitis (*buhama*), and cholera. People recall that, in their original residences, incidences of communicable diseases were low. This situation might have been attributed to the sparse distribution of the population: “In the [new] villages, many people died. They died due to the problems and from cholera. Before we moved to Ujamaa villages, there was no cholera; we found it only with the decline in water supply [in the Ujamaa villages]. After two years of being in the village, that is when we heard about cholera. In our old villages, there were no latrines, but in the village we would use latrines.”¹²⁸

In some places, seasonal conditions were not taken into consideration and extreme weather increased morbidity and mortality rates. Vulnerable groups were infants, children, old people, and pregnant women. Extreme weather (heavy rains), famine, and a lack of shelter exacerbated vulnerabilities. One healer in Mwanza stated that, during the villagization period, large numbers of children died due to airborne diseases such as measles.¹²⁹

In addition, respondents noted that some of the diseases experienced were previously unknown. In addition to the hardship of disease, famine was another problem that devastated many families through malnutrition and death. The magnitude of health problems for the population was aggravated by poor living conditions, congestion, poor sanitation, unhygienic practices, consumption of contaminated food and water, and lack of shelters. Another respondent said, “Villages lacked a supply of water, and despite

¹²⁸ Interview, Neche Hango, Kanyama-Magu, August 1, 2006.

¹²⁹ Interview, Neche Hango, Kanyama-Magu, August 1, 2006.

being provided with hospitals and schools, life was still difficult.”¹³⁰ In addition, not all villages had health centers and personnel because some health units were built only after people had moved to the new territories. In the new settlements, healers’ ability to respond to diseases was limited for various reasons. They had lost their medicinal materials from their familiar landscapes. They were presented with new and unfamiliar epidemics. They were accused of practicing witchcraft. Thus, they were not given support; instead, they were criminalized.

The ability to address health challenges was complicated by the poor economic conditions at that time. Many families had a weak economy, in part due to the loss and damage of their properties during resettlement. Respondents have complained about limitations in managing their farms on their original sites, famously known as *mahame*.¹³¹ These farms, some with crops still in the fields, were left unattended. This lack of oversight allowed wild animals and birds to feed on crops and damage cultivated land. Adapting to new settlements was also a challenge because of a lack of finances and because of the inadequacy of market goods. The supply of household goods, such as clothing, soap, edible oil, sugar, salt, batteries, kerosene, corrugated iron sheets, and soft drinks, were scarce or nonexistent (Sanders, 2008) and if one managed to acquire these items, that person was labeled a *mlanguzi* (exploiter). In addition, supporters acknowledge this acquisition effort and argue that the villages were a way to create a strong sense of national identity (Ibhawoh and Dibua, 2003).

¹³⁰ Interview, Manja Buba, Lugeye “A”-Magu, July 24, 2010

¹³¹ *Mahame* are places where people were living before moving to Ujamaa villages.

In some situations, people had to rely on the goods sold by *maduka ya ushirika* (cooperative shops), which lacked necessary basic needs. Communities experienced shortages of consumable goods and necessary services due to restrictive importation laws and laws against “economic sabotage,” which discouraged accumulation of stocks (Askew, 2006). Poor settlements, lack of services in some areas, and congestion forced people to move back to their *mahame*. This return to their lands, though informal and not supported by the government, resulted in reduced congestion in new settlements.

Robbins (2008) argues that the results of villagization were disastrous, suggesting that famine and the poor economy that followed in successive years were mainly a result of poor planning of Ujamaa villages. He argues that huge imports of food were necessary from 1973 to 1975 because of the immediate decline of agricultural production. Many circumstances have been provided as the reasons for the famine experienced in the new settlements. Various reasons include seasonal variation, the loss of farming equipment, the disruption of kinship, diseases that ravaged new settlements, experts’ introduction of adaptations farming methods in Ujamaa villages, and the abolishment of farms and traditional ways of undertaking agricultural activities.

CHANGES IN THE FIELD OF TRADITIONAL MEDICINE

INCREASED IDEAS OF WITCHCRAFT

Although most of the problems and deaths from communicable diseases in the Ujamaa villages could have been attributed to poor sanitation, congestion, and extreme weather, some placed blame upon witchcraft. Literature indicates that stressed communities, particularly in sub-Saharan Africa, are more likely to pursue ideas and

accusations of witchcraft whenever challenged by health conditions, security matters, or a lack of financial resources (Stroeken, 2001). Multiple factors contributed to witchcraft accusations in Ujamaa villages, such as tension and conflicts over land between newcomers and hosts, damage to farms by livestock, disease outbreaks, deaths, and a lack of secure new premises to implement protective medicine. Many respondents highlighted tension over land. For instance, a non-healer residing in Ukerewe Island noted conflicts and witchcraft accusation were common in the new settlements and were mainly caused by a lack of and/or fight over land. The ownership of land and lack of it thereof manifested in power relations in communities particularly when individuals who owned land or given land boasted. These boasts created ill feelings in the individuals whose land was taken. Consequently, threats and witchcraft accusation emerged. People who became ill blamed witchcraft. New migrants were not welcomed; in turn, they accused their hosts of bewitching them, especially when they experienced illness and death. The conflicts were further aggravated by situations in which migrants were reluctant to return to *mahame* because they had never owned land in *mahame*, or their land in *mahame* had been allocated to other parties.¹³²

Brain (1982) links the rising incidences of witchcraft accusations in Tanzanian Ujamaa villages to high child mortality rates. According to Harry G. West, referring to the work of Mesaki (1984:55), villagization in Tanzania exacerbated witchcraft accusations in the view of village residents. A respondent in Mwanza echoed the relationship between migration and witchcraft by noting it was during the Ujamaa villagization period that people started hearing words such as *kijiji* (a village), *bushirikina*

¹³² Interview, Paul Zambe, Gallu-Ukerewe, June 28, 2006

(sorcery), and *nsami* (migrant).¹³³ This suggests that, despite the existence of these ideas in Sukumaland in the past, they became more conspicuous in Ujamaa villages. In addition, the closeness of people in Ujamaa village enhanced jealousy, one factor that could trigger witchcraft accusations (Ashforth, 2005). A healer in Mwanza summarizes the lack of trust and confusion experienced in Ujamaa villages, “Imagine only one acre, and then you have livestock invading other people’s farms, lawsuits increased; witchcraft accusations also increased; and crimes also increased”¹³⁴

Magic and religion are so intertwined among Sukuma people that they cannot be easily distinguished (Wiljsen and Tanner, 2002). Magical ideas are part of a rational system of explanation for a wide range of events, a point of view shared with religion (Brain, 1982; Wiljsen and Tanner, 2002). Wiljsen and Tanner also argue that magic has always been part of humankind’s explanation for occurrences in the world. A distinction between religions and magic is simply the disapproval of what is called magic, but there exists “a constant and dynamic struggle of different forces within religion. Any attempt to separate one from the other turns religion into bloodless spirituality and the magic into an uncontrollable and destructive force” (Schaefer and Kippeneberg, 1997: xi)

Attacks against witchcraft suspects using machetes (*panga*) increased and were reported in different parts of Sukumaland during Ujamaa villagization.¹³⁵ Diviners, people known for their supernatural power of foretelling and identifying witches, were blamed for instigating witchcraft accusations by identifying and exposing witchcraft

¹³³ Meeting at Bujora Sukuma Museum, Fr. Nicodemus Salu, June 23, 2006

¹³⁴ Interview, Nyanga Mangala, Igekemaja-Magu August 21, 2006

¹³⁵ Interview, Nhumbu Bumila, Bujora Cultural Museum – Kisesa, June 23, 2006

suspects. These claims made the suspects susceptible to attacks.¹³⁶ As has been argued elsewhere, such as Salu,¹³⁷ it is hard to distinguish between healers and witches, particularly for Sukuma people. The distinction is complicated by the modes by which healers receive and use their medical knowledge. One of the interviewed healers noted that healers have to attend to and treat natural conditions as well as those inflictions arising from witchcraft. To counter witchcraft, healers themselves need to have knowledge of witchcraft, particularly when prescribing therapies for protection or for countering the effects of affliction associated with witchcraft. For instance, according to the interviewed healers, for afflictions related to witchcraft, the healer's task is to first neutralize the power of witchcraft that comes with the disease before addressing the symptoms.

The presence of the Witchcraft Ordinance of 1928, which was amended in 1956, did not improve the situation in Ujamaa villages in the 1970s. Witchcraft accusations were prevalent in Ujamaa villages and the government was reluctant to abandon locally initiated anti-witch activities. Despite local anti-witch activities, accusations and witchcraft-related murders continued in the modernized Ujamaa villages. The period between 1970 and 1988 recorded about 3,690 people killed in witchcraft-related incidents in Tanzania (Mesaki, 1993; Stangeland et al. 2008 quoting Marshall, 1998). Mesaki also shows that there were 3333 witch-related incidences reported to police departments in 13 regions of Tanzania between 1970 and 1984. Sukumaland accounted for 2120 cases and

¹³⁶ Interview, Fr. Nicodemus Salu, Bujora Cultural Museum -Kisesa, July 1, 2006

¹³⁷ Interview Fr. Nicodemus Salu, Bujora Cultural Museum -Kisesa, July 1, 2006

2246 deaths during the same period. Miguel (2004) and Mesaki (1993) further indicate that between 1970 and 1988 there were about 3070 accused witches who were killed in Sukumaland. Quarmyne (2011), quoting the HelpAge International, notes that there are about 1000 yearly killings related to witchcraft in Tanzania. The available data indicates also that between 1984 and 1988 there were 827 people who lost their lives due to witchcraft-related violence (Mesaki, p.116). Previously, according to the summary by Mesaki (1993 p.64), between 1935 and 1943 there were about 322 murder cases, 47 of which were witch-related cases.

The murder of people alleged to be witches in the 1970s happened at the time when the use of customary laws was rescinded following the abolishment of chiefdoms in 1962. Prior to this time, customary law, to a large extent, controlled issues of witchcraft accusations (Waite, 1987). Chiefs had been efficient in dealing with local conflicts; their restriction after 1962 created security gaps. Government officials had fewer contacts and less knowledge about communities.¹³⁸ The restrictions upon chiefs and the limited use of customary laws created gaps when dealing with witchcraft problems. In other words, sorcery and witchcraft activities and/or accusations are conspicuous in contemporary settings after abandonment of kinships and chiefdoms (Mesaki 1984; Geschiere 1997)

¹³⁸ Source: *Tanzania suffers rise of witchcraft hysteria*, Accessed on September 14, 2011 from <http://www.independent.co.uk/news/world/africa/tanzania-suffers-rise-of-witchcraft-hysteria-517157.html>

HEALERS CONDEMNATIONS, ACCUSATIONS AND ISOLATIONS

The exercise of Ujamaa villagization was accompanied by condemnation of traditional healing practices. Respondents in Mwanza explained the many different ways in which healers were condemned and accused of practicing witchcraft, and were thus isolated: “The establishment of Ujamaa villages found me when I was in Nyasato. I was grown up, but the Ujamaa villages caused a lot of problems. People lost their belongings, such as food and houses. People’s houses were burnt and healers were accused of practicing witchcraft, and they were tortured. They were summoned, taken, rubbed with hot peppers in their eyes, noses and genitals.”¹³⁹ Another respondent indicated the way in which healers were marginalized. “The situation was even worse for the healers when they were taken to places that were more isolated. Most of the healers abandoned practicing medicine in such circumstances, as they felt they had been ostracized, accused of practicing witchcraft, and been made bereft of the materials they used for therapeutic purposes, such as *shingila*.¹⁴⁰

In order to stop the murder of people accused as witches, the government ordered restrictions to divination. A healer respondent, Luja Kara, had this to say, “Chicken-diviners were condemned and accused that they were telling lies, and consequently their medical materials were destroyed and burned.”

Ujamaa villagization was not without controversial aspects linked to ideas of sorcery and witchcraft. For instance, there were rumors during the Ujamaa village period that healers were releasing ghosts, some of whom were reportedly seen searching for

¹³⁹ Interview, Bale Budela. Nyasato, Ndagalu-Magu, July 24, 2010

¹⁴⁰ Interview, Luja Kara, Kisesa-Magu, August 21, 2006

food in Nassa (Magu district, Mwanza). These rumors were based on the theory that revealing the secrets behind healers' practices would make it impossible to conceal ghosts inside their houses in *mahame*. Such rumors about ghosts indicate the belief that human-induced death-through-bewitchment made it possible for some people to own other people and transform them into ghosts who could perform duties according to the owner's plan.

Rumors circulated that witches were not able to detain ghosts in the new settlements because there were no shelters and because the small allotments to people in the new settlements made it difficult to have privacy and secrets. Therefore, ghosts had to be released.¹⁴¹ These kinds of accusations and allegations continued to alienate traditional healers from others in Ujamaa villages. Healers were directly linked to sorcery and witchcraft. Lutubeja Ng'wana Kafura noted that such situations disturbed healers. Traditional civilization disappeared because healers were jailed and their *shingila* were burnt.¹⁴² When asked about the impacts of Ujamaa villages on the clients of traditional medicines, Kafura stated that people were very much troubled because they were told that they were bewitched. But this belief was, in fact, a lie. Diviners using chickens faced allegations that they were the one who were lying after they told people they had been bewitched as an explanation for even common problems.

Confusion between healers and witches became a conspicuous aspect of Ujamaa villages. Traditional healers known as *bafumu* (diviners) and *waganga* (healers) suffered a great deal. It was difficult to distinguish between *bafumu* (diviners) and *balogi*

¹⁴¹ Interview, Luja Kara, Kisesa, August 21, 2006

¹⁴² Interview, Luja Kara, Kisesa, August 21, 2006

(sorcerers). The respondents noted that *nogi* (sorcery) would kill people with witch-magic, while the *mfumu* (diviners/healers) would provide curative and protective medicines against *balogi* (witches in Sukuma) or wachawi (witches in Swahili).¹⁴³ One of the healers expanded the discussion about the distinction between the two by noting that only *Balogi* (sorcerers) inflict harms and diseases, and that their spirits require killing people.¹⁴⁴ During both the Ujamaa villages period and the present day there was not enough research to determine the difference between *nogi* (witches/sorceries) and *waganga* (healers). People living close to one another aggravated the problems and accusations. Their proximity promoted jealousy and accusations of witchcraft.¹⁴⁵

Differentiating between healers and witches was a problem that persisted for many years. This failure to make a distinction between witches and healers led the government to take measures to further isolated healers. These measures included restricting healers' activities and asking them to secure licenses to practice medicine. Healers were afraid to secure licenses due to the negative publicity of their activities. In addition, the language used on the licenses, Swahili, was not the language commonly used by healers. Thus healers were likely non-proficient in the language used on the licenses. Similar problems persist today; there is still a disconnection between the means of communication used by healers and that used by officials working for government institutions. Many of the interviewed healers do not read Swahili or English; yet, their licenses and governing permits were written in Swahili and English.

¹⁴³ Meeting, Elikana Mtangi, Meeting, Bujora Cultural Museum – Kisesa, June 23, 2006

¹⁴⁴ Meeting, Nhumbu Bumila, Bujora Cultural Museum – Kisesa, June 23, 2006

¹⁴⁵ Interview, Nhumbu Bumila, Bujora Cultural Museum – Kisesa, June 23, 2006

In Ujamaa villages, the accusations of witchcraft dominated. Initially the government had to allow locally initiated anti-witch activities. The government was concerned that the presence of witches could create a challenge to the settlement of people in Ujamaa villages. Attempts to deal with reported incidences of witchcraft in Ujamaa villages were hampered by other factors as well, such as weak legislation. Nevertheless, the government trusted and gave sanction to witch-hunters who were mainly traditional healers or diviners originating from within communities. At first these healers and diviners were trusted and even called *mganga was serikali* (government witchdoctors) because their medicinal knowledge was seen as an antidote for witchcraft (Green 1994; West 2005). West (2005) quoting Green (1994:30), notes that, “the Tanzanian government attempted to ban anti-witch specialists from working in its Ujamaa villages in the 1970s but relented to prevent the breakup of these villages as a consequences of witchcraft and festering accusations.”

People interviewed in Mwanza noted that coercive forces used to deal with the suspects of witchcraft – the majority of whom were traditional healers – were different than the treatment given to other members of the community. People alleged to be witches, including traditional healers, were sent to jail and experienced severe punishments under the emblem *operesheni wachawi* (anti-witchcraft movement). This exercise was aimed at purging all elements of witchcraft in the new settlements. However, discerning the witches from the healers was not an easy thing. Ultimately they were all combined in the same category: witches. In 1976, *Operation Uchawi*

apprehended healers who did not have licenses. This action caused many healers to abandon their activities because they were all suspected witches.¹⁴⁶

The government-sponsored anti-witchcraft movement was undertaken sporadically in Mwanza. However, it was most effective in Shinyanga (part of Sukumaland). A regular resident of Kisesa recalled the impact upon healers in the Maswa district in Shinyanga. “In Shinyanga healers were associated with witchcraft and they were very much troubled, hot pepper was put into their eyes and nose, and generally they suffered!”¹⁴⁷

However, the harsh action taken by the enforcement agencies led to a public outcry. Government agents were accused of torture and harsh jail conditions for those arrested for practicing witchcraft. The impact of anti-witchcraft actions in the mid-1970s not only transformed the position of healers but also the political structure of the country. The excessive force used to punish those suspected of witchcraft created a backlash in the political system. These actions so tarnished the images of those responsible in the Ministry of Internal Affairs that the leaders had to submit their resignations. In the subsequent political shake-up, the Minister for Internal Affairs, Ali Hassan Mwinyi resigned, though Mwinyi later became *Rais wa Awamu ya Pili* (the President of the second presidential phase in 1985 -1995).

Minister Mwinyi’s letter of resignation to President Nyerere appeared in *The Dailynews* in 1977. In it, Mwinyi stated that he was taking responsibility for the excessive use of force that caused harm and injury to the suspects. Mwinyi noted that the

¹⁴⁶ Meeting, Fr. Nicodemus Salu, Bujora Sukuma Cultural Museum, June 23, 2006

¹⁴⁷ Interview, Jogu Numa, Kisesa, August 1, 2006

excessive force used by police and prison officials (both institutions under his ministry) when dealing with people who were suspected as witches was not appropriate. He also said that the actions of those under his authority were unacceptable and were taken without his knowledge, that these actions led to deaths and permanent disabilities to the suspects, and that these actions were against the Tanzanian constitution. He acknowledged that police officials are mandated to maintain social order and protect people's lives, not to kill. Mwinyi further stated that he was not aware and was never informed of the various actions until the end. However, he noted that he could not escape blame because the incidents took place through the offices of his ministry while he was in charge. Thus, he claimed responsibility for what happened.¹⁴⁸ President Nyerere accepted his letter of resignation. Minister Mwinyi was not alone in taking responsibility. Others who publicly accepted blame included the Regional Police Commander and the Area Commissioner for Shinyanga.

Both the Ujamaa Villages Act of 1974 and the anti-witchcraft actions initiated in 1976 have had repercussions in the development of the traditional medicine as an institution. In some ways the development process of the field was impacted. Since many people avoided practicing medicine during this time, their knowledge acquisition was limited. Simultaneously, the public image of the field has been negatively impacted. Additionally, the loss of medicinal materials – whether burned, confiscated and otherwise destroyed – coincided with the loss of knowledge. All these aspects had impacts on the consumers of traditional medicine in Tanzania that continue to this day.

¹⁴⁸ Letter of resignation from Mwinyi (the minister for internal affairs) to the President Nyerere recorded (*Dailynews* Monday 24, 1977)

KINSHIP ALTERATION

The Ujamaa villages altered kinship relations as people were forced to move to new places and were confined in small houses. This situation forced the younger generations to opt for new life styles, such as moving to faraway places or to urban areas. This population movement created a gap in knowledge transfer as the original teaching methods became more difficult to recreate. One important method was the use of *shikome*, a formal gathering at which parents and grandparents shared knowledge with their children and grandchildren. These gatherings, held by people sitting in a circle around a dung fire, were restricted or were not tenable in Ujamaa villages. A non-healer respondent in Kisesa referring to the importance of *shikome* noted:

Shikome was a setting for communication happening every night; it was a family meeting involving males and females. However, they were the males sitting outside surrounding fire. It was important meeting and it was aimed at offering lessons and planning for next day activities. Everybody went to sleep knowing the tasks for the next day. Any misconduct involving family members was addressed at *shikome*. For instance, if a young member of the family was negligent allowing livestock to graze others people's farm, then he was liable for punishment at *shikome*. This setting created social order, and it was not easy making *shikome* in Ujamaa villages as the focus was on Western education.¹⁴⁹

According to the interviewed healers, establishing such a setting (*shikome*) in Ujamaa villages was complicated by the size of land-parcels given to each family, the lack of animal dung to burn, and the emphasis on sending children to formal schools. In other words, settings in Ujamaa villages were designed to accommodate the modern and, to a large extent, were restrictive to traditional ways of life.

¹⁴⁹ Interview, Pasori Maga, Kisesa, August 3, 2006

The network between healers and patients not only allows for the flow of medicine into the body; this network is also a flow of medicinal knowledge from healers to patients. Taylor (1992) has used the concept of ‘flow’ to discuss the coexistence of traditional and biomedical therapeutic options for people in Rwanda. Flow of the human body fluids (blood, milk or semen) characterizes the state of the human health. This same concept is extrapolated to explain the movement of material in economic transactions, production activities, and circulation of gifts. In other words, the society will flourish if there is a continuity and optimum conditions for material circulation, akin to circulation of body fluids in humans. Healers in such circumstances and landscapes became the mediators facilitating and ensuring the flow or blockage of body fluids in the maintenance of health.

In many ways, the establishment of Ujamaa villages restricted some forms of flow, such as medicine, knowledge, labor exchange, gifts, and compensations between healers and their clients. These restrictive conditions altered the mediation by healers between the natural environment and people’s health. The interviews with healers show that different forms of flow in Ujamaa villages were restricted. For instance, not all patients had the capacity to pay for the medical expenses they incurred, but they trusted in the built kinship relationships that evolved between healers and patients. This was more common in the past particularly in rural areas and was known as *bahemba* (inherited kinships through treatment). Patients who had to stay a long time with healers received training in collecting, processing, storing, prescribing, and administering medicine. In the process, they also established new forms of relationships among other patients and gained knowledge about therapies and different health conditions of other

patients within communities of healers. Healers who were interviewed noted that they learned about medical practices through apprenticeship in the form of healer-patient relationships (Details in Chapter Two).

LIVESTOCK MANAGEMENT

Livestock ownership among Sukuma people demonstrates power, livelihood, social relations, and insurance during difficult times. Sukuma healers, particularly those in residing in rural areas, were more likely to own livestock. Wiljsen and Tanner (2002 p.68) note that Sukuma people do not use livestock for immediate financial gains; instead, livestock serve as a symbol for Sukuma people to demonstrate their wealth. However, apart from being used for meals during rituals, livestock (cows, goats, and sheep) were sacrificed in rituals performed by healers, and some of their body parts were buried or eaten to signify specific rituals. In addition, the packaging of medicine was more often done using horns and animal hides from goats, cows, sheep, and wild animals. The Ujamaa village exercise changed the system of cattle owning for healers, just as it did for other Sukuma people. The new settlements did not allow enough space to raise cows and other livestock. Owning cows became a problem. Livestock could damage neighbors' farmlands and crops and thus create tension, conflict, and enmity, particularly between those who owned cattle and those who did not.¹⁵⁰

Before the Ujamaa villagization period, Sukuma people lived in scattered areas capable of maintaining large herds. The scattered settlements also reduced the impact that livestock had on the environment, such as soil erosion and land degradation. In Ujamaa

¹⁵⁰ Interview, Seleta Kadulu, Iseni Bondeni-Kisesa, June 20, 2006.

villages, the space for owning cattle was restricted. Herding was in concentrated areas of Ujamaa villages and these conditions devastated limited grazing fields. Some healers experienced losses of livestock due to changes of the environment. Livestock died in the new settlements because they were confined to the same areas in which people lived.¹⁵¹ In addition, due to overcrowding, animals were ravaged by diseases such as rinderpest and east coast fever. These conditions killed large herds in a short time. In some families, people and animals had to be housed in the same building.

MEDICINAL BASE INTERFERENCE LAND DEGRADATION AND DEFORESTATION

The literature extensively covers the presence of rain specialists in societies that worked collaboratively with chiefs and their subordinates, famously known as *wanangwa* (assistants to the chiefs). In addition, there were the *wanangwa* who could consult diviners to predict if it was a good year for growing. Disrespect for rain specialists and diviners was unwelcome because that attitude could cause a bad year. The extent to which the change in the role of chiefdoms and their rain specialists affected the weather patterns are not known. There is evidence that rituals are conducted at the graves of rain specialists as a symbol to venerate them and appease the spirits to bring rain (Covered in detail in Chapter Eight). However, rainfall is conventionally thought of as an outcome of natural processes; therefore, the influence of rain specialists was neglected by the independent government.

¹⁵¹ Interview, Mara Ikimba, Iseni and Changambe, June 20, 2007.

The ability of rain specialists to bring rain is contested by conventional scientific knowledge. Recently scientists have started to discuss the role and the contribution that rainmakers can have in predicting climatic conditions or in dealing with climate change issues (Naess et al, 2011). The newly independent government contrasted the previous system in which chiefs acknowledged the presence of people who could influence weather pattern. Chiefs assumed the role of distributing land and ensuring that conditions were suitable for growing food; this function gave power and stability to the chiefdoms. An 80-year-old respondent in Gallu Ukerewe explained the tasks of chiefs that demonstrated their power and authority through improvement of ecological and social conditions in territories they governed:

Prior to Ujamaa villages, the wanangwa had a role in distributing land to the people, even though there were communal plots. Personally I was given three acres for myself, two for food and one for cash crops (cotton and rice). I still have this land but now my relatives use it. Under chiefdoms, people would be given land in the amount necessary for them to survive. However, chiefs were aware of the importance of having a community that had adequate food supply. One of the conditions for subordinates was to have a specialist who could make rain. Chiefs, while supported by their *wanangwa* (assistants), had the responsibility to ensure that every household had land to grow food. Therefore, chiefs selected their assistants (*wanangwa*), some of whom were rain specialists. If the situation could have been different, chiefs consulted diviners in order to determine if anything went wrong and if there was any form of ritual that was supposed to be done to ensure adequate rainfall that would ensure the community having enough rain to produce enough food. Neglecting the role of rainmakers and diviners was an offence and could have caused drought and poor yields and the effect would have been on the chief who would be asked to resign. Things have changed now that rain specialists are not respected, no longer exist, and rituals for rainmaking are not done.¹⁵²

There is consensus that anthropogenic activities influence climatic changes such as global warming and changes in rainfall patterns. Anthropogenic activities such as

¹⁵² Interview, Andila Makele, Gallu-Ukerewe, June 28, 2006

clearing forests and releasing greenhouse gases from forest burning have an effect on weather patterns. Rituals, on the other hand, were traditionally done in areas that, to some extent, conserved forests and biodiversity (See Chapter Eight). In other words, the presence of rainmakers served both direct and indirect purposes in the rainmaking process (e.g. it has a direct effect on the rainmaking and an indirect effect on aspects vital for the rainmaking processes, such as conserving forests).

The creation of Ujamaa villages added pressure to the environment as new settlements cleared the land and increased the concentration of human activities, such as grazing, cutting trees for construction and firewood, and charcoal-making (McCall, 1985



Figure 13: A tree planted by Nyerere at Igekemaja Primary School

p.13; Guggenberger et al, 1989). These conditions affected the medicinal base (ritual places as well as places where medicinal flora and fauna were obtained). A respondent in Kisesa-Mwanza noted this impact when he observed that some residents went to clear bush (*kusenga*) for Ujamaa villages; this activity destroyed places where medicines were obtained.¹⁵³ Generally, when the exercise of Ujamaa villages was executed, many areas were deforested due to their establishment.¹⁵⁴

Although not widely covered in the literature, environmental conservation was not forgotten in Nyerere's vision of Ujamaa villages. In establishing new settlements, Nyerere imagined the ideal landscape. He emphasized tree planting around newly

¹⁵³ Interview, Elikana Mtangi, Bujora – Kisesa, June 23, 2006

¹⁵⁴ Interview, Simo Rashi, Sanungu - Lugeye Village, August 1, 2010

established schools and hospitals (Figure 13 and Figure 14).

Nyerere himself participated in tree planting projects in some of the villages. People's narratives in Igekemaja village in Mwanza



Figure 14: Dilapidated school building built in Ujamaa villages – Itira, Ukerewe - 2006

reveal Nyerere's efforts to have trees in schools, and he is

remembered for the tree he planted at Igekemaja Primary School in one of the Ujamaa villages.¹⁵⁵ The tree (Figure 13) for instance is also labeled with the name and date when it was planted in 1974. It has survived for more than four decades. Planting trees was aimed at landscape restoration and improvement of amenities for schools and health centers. Many schools and health centers established during the villagization period have trees that were planted at that time.

IMPACTS TO THE CONSUMERS/CLIENTS OF TRADITIONAL MEDICINE

The creation of Ujamaa villagization had a spillover effect on the consumers of traditional medicines. The narratives from healers and non-healers alike indicate there was only limited use of traditional medicine in the Ujamaa villages. This limited use was attributed to a number of reasons: the increased number of dispensaries in new settlements, the advertisements and public campaigns that emphasized the use of

¹⁵⁵ Interviews, Mara Ikimba, Iseni Bondeni, June 20, 2007

biomedical services such as dispensaries and health centers, the negative image of traditional healers as backward, and the association of healing practices with witchcraft. Healers acknowledged and responded to the challenges experienced during Ujamaa villagization in many different ways. Some abandoned practicing medicine. Some practiced medicine among the people they knew, and some expressed their anger with the project through songs.

These responses do not to suggest that the field of traditional medicine was completely abandoned; rather, people continued using it sporadically, particularly for conditions left uncured by biomedicine. Sick people in Ujamaa villages were also affected, especially those who felt that they suffered from “supernatural maladies” (diseases inflicted by bewitchment that requires antidote from traditional healers). In such cases, these people felt they needed attention from traditional healers who were not there. However, since there were so few people practicing traditional medicine in Ujamaa villages, it was difficult to get services from healers. As one of respondents recalls:

In the Ujamaa villages in 1974, healthcare services from traditional healers were hard to find because there were very few healers operating in the village. In our village there was only one healer known as Mbuke – Luhalula and he was a diviner at Sayaka- Masanza. The other one lived very far. When you receive treatment (from Mbuke), you were supposed to pay with cows and not money.¹⁵⁶

In many different ways, the use of traditional medicine was limited. Healers were reluctant to practice traditional medicine in Ujamaa villages. They feared being targeted by the government because the healers influenced people to follow traditional ways-of-life. Some regular community members interviewed in Mwanza also noted the loss of

¹⁵⁶ Interview, Maja Jame, Living at Hinda – Lugeye village, Magu, April 28, 2010

medicinal plants caused by clearing of land for new settlements in Ujamaa villages. However, they pointed out that Ujamaa villages did not have solely negative impacts on the field of traditional medicine. Surviving healers were brought closer to many people; thus, traditional medicine was more easily accessible to a larger population.¹⁵⁷ The presence of traditional healers allowed clients to obtain therapies for conditions that they felt could be treated by traditional medicines. Even so, the presence of healers in Ujamaa villages was ambivalently received due to negative publicity about their practices. People were reluctant to consult healers to seek traditional medicine. Some respondents noted that there were not many healers operating in Ujamaa villages and their practices were limited to the few clients that they knew personally. Other healers who were still interested in practicing medicine in Ujamaa villages were challenged by the lack of licenses (that were rarely issued at that time) A license was one of the conditions to practice medicine.¹⁵⁸ Healers did not trust all their clients, suspecting that some were government agents sent to investigate witches in Ujamaa villages. In addition, people opted for services other than those offered by healers, due to the public discouragement of using traditional medicine.

Traditional healers were forced to move away from their homelands and were subsequently relocated in places that were far from their ritual places and clients. Some clients were separated from healers they knew in prior Ujamaa villages and it was difficult to find them.¹⁵⁹ People and consumers who depended on traditional medicine suffered as a result. Clients did not know the whereabouts of healers they knew, and were

¹⁵⁷ Interview, Paulo Zambe, Gallu-Ukerewe June 28, 2006.

¹⁵⁸ Interview, Hili Malasa, Kisesa, August 20, 2006

¹⁵⁹ Interview, Hili Malsa, Kisesa, August 20, 2006

reluctant to consult healers they did not know.¹⁶⁰ With many of the surviving healers living in faraway places, clients were forced to travel long distances and to spend a lot of money in search of those healers they knew. Other respondents noted that during the Ujamaa villages exercise there were healers whose patients' courses of treatment were affected as the healers' settlements were interrupted.¹⁶¹

In addition, traditional medicines were considered lacking in standards,¹⁶² and were disparaged; this is a line of argumentation that still exists (Bodeker and Kronenberg, 2002; Bodeker and Gemma 2008). The mutual misunderstanding and mistrust between modern and traditional practitioners, weak organization among traditional healers, and weak support from both the governments and media all contribute to the marginal status of traditional medicine in African countries. As a result, scores of medicinal plants that are used daily in Africa that may have potential effectiveness against opportunistic infections or HIV remain unknown or uninvestigated.

CONCLUSION

Healers form a reservoir of medicinal knowledge that is attached to the knowledge of their culture, health, and environment. Apart from their medicinal knowledge, healers remain an important group for understanding the different political and economic processes, and various environmental changes occurring in societies. My fieldwork in Mwanza reveals new dynamics about the traditional healing perceptions and

¹⁶⁰ Interview, Gamella Lugasha, Kisesa, July 5, 2006

¹⁶¹ Interview, Jogu Numa, Kisesa, August 1, 2006

¹⁶² Interview, Jogu Numa, Kisesa, August 1, 2006

practices that emerged in response to changing social structures and political systems that were influenced by the creation of Ujamaa villages. Healers had to respond and adjust to new environments with new political structures.

Ujamaa villagization created conditions that directly and indirectly impacted the field of traditional medicine. Healers received harsh treatment from officials who supervised the Ujamaa villagization projects merely because these healers were seen as a powerful group in a society. Healers' power stemmed from their position as a group that could have destabilized the resettlement and development programs introduced by the government. Thus, healers were coercively moved and those who resisted were caned and jailed. They lost materials used for therapeutic activities, experienced difficulties in obtaining medicinal flora and fauna in new settlements, encountered new environments that were not familiar to them, and feared practicing medicine because of negative publicity about their practices and because of the arrests they experienced. Healers lacked space to house their patients/clients. Society disparaged the field of traditional medicine in the new settlements so people were uncomfortable going to the healers. Moreover, traditional medicine received less recognition from the public due to increased access to biomedicine. Media programs emphasized modern health care, the biomedicine. The emphasis on biomedicine and the disturbance experienced by healers during Ujamaa villagization were the drivers that led people to a greater preference for biomedical services. A resident of Usagara, in Mwanza, noted, "On our side we preferred using biomedical units, despite the fact that my father knew about traditional medicine"¹⁶³

¹⁶³ Interview, Julisa Shilanga, Usagara-Mwanza, June 22, 2006.

Healers, as part of the community, experienced other problems that were common to other members of society, including famine, rural-to-rural migration, rural-to-urban migration, poverty, and attendant problems that followed in subsequent years. The Ujamaa villages became places where traditional ways of life were considered backward and where new approaches were valorized. In Ujamaa villages people had to respond to the outbreak of communicable diseases, conflict over land acquisition and ownership, and conflict over livestock management in confined spaces where crops and personal properties were damaged. In addition, the presence of other people who now lived in close proximity compromised privacy and security issues in new settlements. Land-based conflicts and violence broke out between migrants and natives, giving rise to accusations of sorcery (Stroeken, 2001). Villagization increased accusations of *bushirikina* (witchcraft), often in the context of land disputes between *bazengi* (natives) and *basamiji* (migrants).

There are myriad long-term impacts to the field of traditional medicines caused by the Ujamaa village project. The number and kinds of medical materials that were lost, destroyed or burnt during the resettlement project remains unknown. The number of healers who abandoned the practice of medicine as a result of the creation of Ujamaa villages remains unknown because there were no records to identify those who initially practiced traditional medicine. The loss of important medical fauna and flora due to land clearing for settlements is unknown. Finally, it is difficult to quantify the way in which ritual activities and space were changed by the villagization exercise.

What can be established from the narratives, however, are different ways in which healers were affected. These include the relationships between healers and their clients, the environments in which healers operated, and the perceptions about healing practices. All of these aspects were changed and transformed due to healers' public linkage with witchcraft. One healer who also participated in dancing Sukuma groups noted that the impacts during Ujamaa village to the healers are related to the restrictions that healers experience now:

During the exercise of Ujamaa village I was dancing traditional *ngoma* (dances). In general villages retarded our progress, because people had to start afresh in rebuilding their lives. For instance, healers were beaten and peppered in their genitals, and at the same time restricted from practicing medicine. From then until now, healers have been experiencing difficulties.¹⁶⁴

Traditional medicine is embedded in culture; all obstacles that may be imposed upon it only create conditions for the field to reinvent and respond to changes within societies. The continuity of traditional medicine depends upon demand by people, as well, to determine the way in which healers can create conditions to use their traditional skills to rebuild their fame, autonomy, and power. Despite a lack of support from and efforts to suppress them by the government, practitioners were not completely deterred, though their activities were altered. Throughout its existence, traditional medicine and the actors within it have been institutions that continued as distinct entities. Previously, colonial powers, both political and religious, deliberately suppressed the application of

¹⁶⁴ Interview, Mano Yenze, Nyasato –Minoang'ombe, Ndagalu Magu, July 24, 2010

traditional medicine without success (UNAIDS, 2002).¹⁶⁵ Healers have taken different approaches to resist various forces that restrict the practice of their medicine. Some of these approaches were passive; however, in some cases healers strove to become part of the political system by presenting themselves as security agents for areas embroiled in crimes. One of the approaches used by healers to reclaim their identity and power is their active participation in the formulation and involvement in Sungusungu Vigilantism as shown in the following chapter (Chapter Four: Traditional Medicine a Mobilizing Tool for Sungusungu Vigilantism).

Likewise, the field of traditional medicine is currently transforming and responding to the global discourses about epidemiological crises and healthcare systems. For instance, the field of traditional medicines appears to be bolstered by the need to respond to HIV/AIDS and degenerative diseases. Despite wide application, traditional medicines continue to be affected by its diversity and lack of standards. One of the challenges in dealing with traditional medicine is the oversimplification and use of reductionist approaches that confine the entire field to the physiological health aspect while ignoring the cultural, security, economic, and political aspects. In other words, traditional medicines do not simply address physical wellbeing. Instead, traditional medicines include political, cultural, society, community and family wellbeing.

¹⁶⁵ – Ancient Remedies, New Disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa, http://data.unaids.org/publications/irc-pub02/jc761-ancientremedies_en.pdf.

CHAPTER 4: SUNGUSUNGU VIGILANTISM: TRADITIONAL MEDICINE, A MOBILIZING TOOL IN RESTORING SECURITY AND SOCIAL ORDER

Traditional medicine as a mobilizing tool in the sungusungu social movement in restoring security and social order in north-central Tanzania –
-search for identity and autonomy among healers following marginalization during ujamaa villages.

During the 1980s in an area of north-central Tanzania called Sukumaland, a social movement known as Sungusungu evolved to address the lack of law enforcement related to numerous social and security issues, including robberies, cattle rustling, witchcraft, and other crimes.¹⁶⁶ Sungusungu is collection of aggrieved groups and individuals mobilized to work together for the common good. It is a broad-based consensus movement that works for the common goal of providing community health and security. This chapter looks at traditional medicine as non-traditional tool to influence a political process that manages social tensions within the community, the government and the private sector that was empowered by Sungusungu. This movement relied heavily upon

¹⁶⁶ Interview, Bonika Bungi, Nyasato- Ndagalu, October 15, 2009.

the recruitment and acceptance of community members for purposes of collaboration and collective actions that were vital to its success.

Different explanations exist regarding the origin and use of the word “*sungusungu*.” *Sungusungu* literally translates to “black safari ants” and army officials wore black clothes to represent the eponymous ants. The *Sungusungu* movement mirrors the collective action of black safari ants. The ants collectively fight back by stinging and causing severe and prolonged pain to their attackers when threatened. *Sungusungu* is reported to have originated in the Kahama district, Shinyanga region (Abrahams, 1987; Bukurura, 1996; Heald, 2002).

Others have suggested that *Sungusungu* originated from the word *busungu*, which may indicate both poison and labor pain (Abrahams, 1987). *Sungusungu* symbolizes the pain for humans when poisonous creatures bite them. *Sungusungu* rubbed poison on arrows to inflict pain and even death as part of their practice. *Sungusungu* operations were guided by the principle that criminals had to be subjected to severe punishment to deter repeated criminal acts. As these possible word origins suggest, *Sungusungu* was an aggressive response to criminals in an effort to secure social order and harmony (Bukurura, 1996; Heald, 2002; and Nkonya, 2006).

Nkonya (2006) notes that *Sungusungu* emerged as a local institution aimed at protecting property and enforcing customary laws in response to cattle rustling. At the time when the organization was established, cattle thieves no longer restricted their actions to cover of night. They had become so bold that they would attack, kill and then tie headmen to trees in daylight (Heald, 2002). I argue that *Sungusungu* was a unique social movement that used traditional medicine to mobilize and energize people. Within

this movement, traditional medicine was a social force to reclaim old identities and to create new ones. This use of traditional medicines reinforced the idea of the Sukuma healing traditions as an autonomous culture after both the former colonial government and the central Tanzanian government had challenged the worth of traditional medicine.

SOCIAL MOVEMENT: REBIRTH

The core component of the Sungusungu movement is the use of traditional medicines. Communities acknowledged that the use of arrows, bows, and spears were not enough to mobilize people and ensure their security. In addition, communities knew that some crimes were attributed to the invisible forces of witchcraft. Therefore, the use of traditional medicine offered the only protection, thinking analogous to the chemistry principle of solvents and solutes that “like dissolves like.” In addition, because there were multiple threats, a collective security system was essential. The importance of traditional medicine in the Sungusungu movement reflects two aspects: the power in witchcraft and the power in traditional medicines. As the literature indicates, initially witchdoctors formed as a group with magical medicine who would use this to counter the effects of others using witchcraft. However, as the years progressed, the distinction between the two groups blurred.

The analysis of traditional medicine as a central component of a social movement is useful to contextualize one way in which a society forms and maintains a collective identity in times of crisis and change. The survival and sustainability of Sungusungu as a social movement depended upon local forms of organization, with their specific cultural repertoires, enacted within the wider state (Heald, 2002). The Sungusungu movement

emerged as a post-colonial, post-Ujamaa village, post-war phenomena. The movement occurred at a time when the country was transitioning from a socialist to a neo-liberal political system.

Before independence, despite the colonial presence in communities, Sukumaland was organized into chiefdoms. Chiefs, through their subordinates, enforced customary laws to deal with crime and social strife in communities. Their mandate covered issues such as cattle rustling, thievery and witchcraft. In addition, chiefs ensured that production processes and security matters were addressed. However, chiefdoms were outlawed in early 1962, a year after Tanganyikan independence. At the same time, the government began the Ujamaa villagization project. These villages greatly affected traditional processes, including the functions of traditional healing practitioners. Over time, people in Sukumaland felt that security gaps in their communities were the result of a lack of locally organized security. This belief became the force behind the establishment of the social movement known as Sungusungu.

To examine this movement, I consider the fundamental relationships between crime and security within the context of the traditional healing sector and within wider political transitions. I integrate primary data and information from unstructured interviews, data from court cases, legislation regarding security matters, and from secondary data comprised of human right reports and media sources.

SUNGUSUNGU : BROAD-BASED STRATEGIES FOR SECURITY

The Sungusungu movement embraced and adapted different strategies from both traditional and modern institutional structures for security, which gave it a unique identity

and autonomy (Paciotti, Hadley et al. 2005). Prior to Sungusungu, during the colonial period, there was an army called *Kisumba*, primarily operated by young people, supported by elders and purposely established to secure order. One of the interviewed Sungusungu leaders, who was also a leader for *Kisumba*, noted, “I was their *Kingi* in-charge of operations. At that time the organization (*Kisumba*) was led by an elderly person who had the title of *Kingi*, an individual selected based on his expertise in traditional medicine. The *Kingi* delegated his duties to his subordinates.¹⁶⁷

To some extent, Sungusungu embraced *Kisumba* as the traditional mode of collective action that was used in Sukumaland to deal with matters related to production and security. Historically Sukuma people relied on collective communal work to attend to matters related to production, security, health and various kinds of ceremonies. The newly established political system distributed government officials to villages, most notably when chiefdoms were abolished. Nevertheless, people continued to help one another during times of *shida* (trouble/grief) and *furaha* (joy). The emergence of Sungusungu was an effort to seek formal recognition for community values, such as the use of locally derived traditional medicine for security. In order to ensure social order within communities, representatives from Sungusungu were involved in policing, patrolling and guarding communities and their members (Nkonya, 2006 p.148, 163).

Marwell, et al. (1988) note that the influence of the organizers is one of the determinant factors for the success of a movement. Many people in different communities were involved in Sungusungu and supported collective action. They

¹⁶⁷ Interview Pachali Monagali, Nkilosha-Ndagalu October 15, 2009; Interview Malasi Chani, Nyasato-Ndagalu, October 14, 2009.

participated in meetings and contributed resources such as money, food, and knowledge of traditional medicine to sustain the movement. The Sungusungu movement was not only for individual benefit; rather, the movement benefitted the entire community and its neighbors. Large numbers of people in communities were involved in the organization of the movement. The collaboration introduced through Sungusungu allowed the Sukuma people to reclaim their identity and their customary laws, and gave an opportunity for practitioners of traditional medicines to redefine their position and importance in society.

One issue to examine is how the Sungusungu managed to survive for many years despite operating outside the legal system. The Sungusungu movement was successful at the beginning because it was able to frame issues in a way that spoke to the security needs of the community. Members of the community were aware of the ideology of the movement; Sungusungu stated the values and goals that allowed for participation. The success of Sungusungu was evident in the reduction and control of theft, debt and adultery (Paciotti and Mulder 2004; Paciotti, Hadley et al. 2005)

Sungusungu achieved success through its ability to mobilize people and resources, such as political influence, finances, and medicinal knowledge. The movement used both voluntary and involuntary approaches to mobilize financial and non-financial resources. Community members voluntarily offered support because they trusted the security offered by Sungusungu rather than private guards. However, because the voluntary mechanism used to solicit resources was not efficient, Sungusungu created new strategies in which members of the community were requested to finance the movement. They obtained additional resources by fining the criminals. Likewise, victims were also

asked to contribute financial resources to enable militiamen to effectively pursue criminals.

Positive social change occurred because the movement involved a network of organizations comprised of individuals and groups of people connected by various personal, structural, cultural and ideological ties. Attracting a broader audience required direct and continual recruitment by the organizational members who were committed to and effective in building social relationships (Abrahamas, 1987; Heald, 2002; 2006). In addition, the movement embraced traditional systems of security that existed in the past in Sukumaland and, thus, presented an opportunity for people to reclaim some of their traditional values. These traditional systems included practices among secret societies, dance societies, and male youth associations that were pertinent to the region in the past (Abrahams 1987; Bukurura 1994). Sungusungu imitated practices among these groups.

Sungusungu was a patriarchal system. Genders were segregated within the Sungusungu social movement and women were excluded from leadership positions, even if they had knowledge of traditional medicines. The Sungusungu movement endeavored to ensure that it had strong and influential leaders who were respected and representative of the movement they governed. The movement did not assign such traits to women. Zald (1969) notes that women have fewer controls over external resources and rarely represent major bureaucratic organizations. Instead, they are socialized to assume more passive roles. This gender socialization and control is also evident in the Sungusungu movement.

In the five villages in the Magu district in which I conducted ten interviews with Sungusungu leaders, none had a woman leader. In all discussions and interviews, representation by women was negligible. Women did play an important role in issues

related to security in the community; however, they were not represented in leadership positions. As Abrahamas, (1989) noted, women sometimes formed separate “women’s wings” of the movement. However, historically, men dominated security matters in Sukumaland. Women were excluded from such activities and assumed other roles and responsibilities within Sungusungu as well.

While men were accused of various crimes, such as cattle rustling or other theft, the majority of villagers accused of witchcraft were women. More often females suspected of witchcraft were treated more harshly than other criminals, often to the point that they were killed by the punishment meted out. If these females objected to the accusation, they were viewed as deviant. Typical punishments were caning or ostracism (*kutulijiwa*.) An ostracized person was not allowed to participate in communal activities, and no member of the community was allowed to visit or collaborate with the ostracized person.

To sustain a movement, individuals must envision longer-term issues and goals in order to create strategies to address future challenges within their organization. Sungusungu survived by expanding its involvement in public concerns about security to ensure the supply of social services. One way the movement worked to protect social services was to punish public servants who did not fulfill their responsibilities. Those public servants deemed irresponsible were fined and caned. Through this move into social services protection, Sungusungu illustrates that, once social movements take public action, they often seek to expand their bases to include sympathetic but non-activist members of their presumed mass constituencies.

They also attempt to enter into coalitions with other social movement organizations whose members are not well known. Social movements deploy strategies to fulfill certain objectives. For instance, each newly enthroned village performed rituals that involved leaders, soldiers, and community members. In one such ritual, participants placed protective medicine along the boundaries of the village. New villages adopting the movement were required to accept enthronement from representatives from a previously enthroned village, often a neighboring one. Rituals like the above were followed by activities such as identifying bandits, witches, thieves, and cattle rustlers through secret ballots. In addition, community members had to identify and propose individuals they thought were competent for leadership positions. Young people in the enthroned communities had to form an army responsible for patrols and arrest of criminals.

The government's approach to dealing with criminals involved investigations, arrests and prosecutions. In contrast, locally established security organizations used customary laws and often used protective traditional medicine. Communities held greater confidence in locally established means and customary laws than the governmental agencies offering security, mainly because Sungusungu utilized collective action within the community. Every adult member of the community was expected to be part of a security system.

SONGS AS A STRATEGIES AND TOOLS OF SUNGUSUNGU

Sungusungu, like any other political entity, has its own propaganda strategies used to mobilize people. One of the movement's most widely employed strategies was the use of songs. Songs, according to Gunderson (2010), gave recognition and identity to

the movement, helped demonstrate its tenacity in pursuing crimes, and boosted social cohesion and morale.

Songs are used to mobilize people. They describe problems existing in society, offer suggestions to solve such problems, motivate and encourage people when pursuing criminals, and they solicit support from government officials. As an example, some Sungusungu songs challenged thieves, bandits, and cattle rustlers to find legitimate jobs (Gunderson 210 p. 436).

Songs of praise were dedicated to people who had contributed to the stability of the country, as well as those individuals who had made the movement successful. Numerous songs exist that praise specific individuals, such as Sitta Kishosha ng'wana Malundi, the founder of Sungusungu. Other paeans were dedicated to the former President, the late Julius Kambarage Nyerere, and the former Prime Minister, the late Edward Moringe Sokoine, to praise their vehement support of Sungusungu. These songs were composed, on one hand, as a strategy to seek legitimacy and authority; on the other hand, these songs challenged leaders to support the movement.

Songs alerted people in the village when a crime had been committed and also called people and the army to pursue the criminals. To track criminals, Sungusungu repeated a call famously known as *ndulilu* or *jalila* that told criminals they were being followed and, if caught, they would face severe punishment (Gunderson 2010 p.438). Some songs informed the public about the kinds of punishment given to the criminals, such as caning; others told of attacking enemies with poisoned arrows and spears and then killing (*iselemagazi*) them without mercy (Gunderson 2010 p444 - 447). More songs were about the need for and benefits of justice in society. Witchcraft is also coded into

the songs; Sungusungu would sing *abasambo na bahumi* (thieves and those who cry like hyenas), and name captured cattle thieves. The phrase “those who cry like a hyena” alluded to the thieves’ cowardly natures as well as their statuses as “friends of hyenas,” a cultural code for witches (p.447).

Gunderson (2010) notes that “bare-foot and bare-chested, carrying poisoned arrows and spears, the Sungusungu dance and sing in a circle around the apprehended thief until the early hours of the morning.” He further notes, “The Sungusungu use songs when they are tracking down thieves, and they also have songs that they use to taunt the thieves once they have been captured” (p.435).

Some songs were sung during Sungusungu celebrations as both entertainment and communication to the members of Sungusungu during meetings. Most of these songs explained the role and strength of traditional medicine in dealing with criminals. Therefore, traditional medicine and songs about them helped to create the position and identity of the Sungusungu movement in society.

CONTEXTUALIZING SUNGUSUNGU AS CONFLICT, RESISTANCE, AND REBELLION

Tanzania, like many other countries, has been affected by the transformation of the global economy. In the early 1980s, the world experienced a major shift in economic activity as globalization processes intensified and catalyzed rapid social transformation in formerly colonized and exploited countries. This was the time in which Tanzania underwent a shift in the political system by adopting multipartism. The government also adopted a liberalized free market economy to replace the failed Ujamaa villages socialist

programs (Wobst, 2001). As explained in previous chapters, Ujamaa villages in the late 1960s and early 1970s was a resettlement project in which people were brought together to access social services and, simultaneously, to form engineered production units. People in these settings relied on security provided by the state, including police forces. Despite the assumed benefits of Ujamaa villages, security issues remained a major concern. People reported crimes such as cattle rustling, robberies, and witchcraft-related accusations and killings. Residents of the villages accused police of corruption because of their failure to respond to these crimes.

People in these newly established settlements viewed their neighbors with suspicion and jealousy. This further exacerbated tension and created mistrust and accusations of witchcraft, particularly in disputes over land and livestock keeping. Addressing witchcraft became a challenge for the government because it did not officially believe in witchcraft. Additionally, the government had restricted the traditional institutions that dealt with witchcraft following the 1962 abolishment of the customary laws and chiefdoms. Sungusungu vigilantism became one of the locally established strategies to respond to witchcraft and related accusations in the early 1980s.

Tensions and crimes in communities were further aggravated by economic difficulties created by the war with Uganda in 1979. The war drained the economic base and disrupted the emerging social structure within the Ujamaa villages. The war with Uganda was Tanzania's first major international conflict since independence in 1961 (at that time called Tanganyika, before uniting with Zanzibar in 1964 to form the United Republic of Tanzania.) Some have cited the war with Uganda as a cause of increased crime in Tanzania (Heald 2005). The end of the war brought home jobless former

fighters, some of whom owned guns that were unaccounted for by the government (Nkonya, 2006). Some soldiers returning from the war were distressed; others felt no remorse for committing crimes.

The cascading effects of war and economic hardships were reflected in various crimes reported in rural and urban areas. While some have attributed crimes in the region to economic hardships and the spillover effects of the war with Uganda, others have argued that the economic hardships in the late 1970s and early 1980s were also a result of the break-up of the East African community in 1977, the end of the coffee boom in 1978, and the second oil crisis in 1979 (Bigsten et al. 1999). Research estimates the government “spent \$500 million—equivalent to 10 percent of annual GDP—for the war,” and that “between 1977 and 1981 the trade index fell from 133 to 85, or by 15 below the 1972 level” (Meena, 1991 p169). Moreover, the country experienced drought and flooding. These natural phenomena caused a decline in food production. The economic problems were also a result of pressure from international lending agencies such as the World Bank (WB) and the International Monetary Fund (IMF). These organizations encouraged the devaluation of the currency (Lugalla, 1995; Stein, 1992). Social theories indicate that economic crises and hardship tend to exacerbate crimes and social tensions. Therefore, as Comaroff and others have noted, economic hardships and social crises in Tanzania tended to influence violent behaviors, security concerns, and ideas about witchcraft (Comaroff and Comaroff 1999).

Tanzanians have always been challenged by security matters such as robbery, banditry, and witchcraft accusations, despite international recognition of Tanzania as an oasis of peace (Linderman and Putzel 2004). Brigandage was another problem that was

widespread along roadways, creating fear among travelers (Abrahams, 1987:1989:2004). Highway robbers hijacked buses and forced people to surrender their money and other belongings. In urban areas, house break-ins occurred more frequently. In rural areas cattle rustling emerged as a major problem. These threats were reported in different parts of the country and the government was not able to meet security needs. In addition, the government faced challenges because of corruption among the police force (Heald, 2002; Nkonya 2006).

Since state security was not sufficient, people in Sukumaland dealt with this mix of perceived risks and real threats with both individual and communal approaches. Perceived risks included fear of unknown consequences attributed to witchcraft. Existing threats involved robbery, banditry, brigandage, and cattle rustling. People used personal security measures, such as fenced-in houses, guard dogs and protective medicine. This protective medicine extended to oneself, one's family members, and one's livestock, homestead and farm. However, the increased magnitude of crimes rendered individual protective mechanisms ineffective. The increased circulation and use of arms also led people to collective protection mechanisms. Thus, people in Sukumaland turned to collaborative methods to find communal solutions to security issues (Bukurura, 1994).

Community members quickly embraced the idea to create *Jeshi la Sungusungu* (a Sungusungu army). Heald (2002) notes that the emergence of Sungusungu was related to the demobilization of the Tanzanian army following the 1979 war with Uganda. The end of the war created a shift from an external war to internal turmoil that the regular forces of the state were unable to control. Paciotti and Mulder (2004) also note, "The combination of a weak state along with the influx of newly armed and unemployed men

led to intolerable cattle rustling rates.” These factors were the motivation for the spread of Sungusungu. People sought locally initiated, historically-based security programs to address crime:

Sungusungu initially arose to combat increasing levels of brigandage and cattle rustling, and there has also been an anti-witchcraft element in some villages; in some communities there is also a women’s wing. A remarkable feature is the groups’ determination to rely purely on traditional weaponry, like bows and arrows. This has probably been vital to their ability to develop alongside formal party and state institutions (Abrahamas, 1989).

The Sungusungu movement started as a loosely connected security campaign but rapidly gained support to facilitate change in the security system of Tanzania (Abrahamas 1987; 1989; Bukurura 1995; Heald 2005, and Paciotti et al. 2005). Two of the most salient features of Sungusungu are the ways the movement dealt with witchcraft and the ways it incorporated traditional medicine in all of its activities. The selection of leaders, for instance, was based on individuals’ knowledge of traditional medicines (though women were excluded even if they had knowledge of traditional medicines.) Leaders used traditional medicine in the initiation process to protect the village and the people involved in the Sungusungu army. Leaders used traditional medicine in rituals to give impetus to the movement and to instill confidence in community members that they were free from threat. Sungusungu dealt with witches by relying on knowledge of the use traditional medicine. Additionally, leaders mobilized people by playing to their fears of and confidence in traditional medicine. Criminals also valued traditional medicine; some used medicines for protection and success in their activities, too.

I argue that different social movement groups use different mobilizing strategies to consolidate their identities and to increase their effectiveness when advocating for

change. In addition, Sungusungu shows a non-traditional approach in which traditional medicine was used as a catalyst to strengthen the movement in an effort to reclaim social order. Sungusungu as a movement adds new dimensions, particularly in the use of traditional medicines. The strength of Sungusungu, to a large extent, was determined by the application of customary laws that were used in the previous eras of chiefdoms and colonial rule, such as caning. At the same time, Sungusungu worked with the current system by helping the police investigate criminal charges and by participating as witnesses in court.

Like a sick individual who seeks curative intervention, these communities challenged by crime sought solutions through interventions by the police or by locally established security systems. One of the local security systems was traditional medicine that could be individually or communally applied. Traditional medicines already had the reputation as protections during wars, particularly in the past when people resisted colonialism. The Majimaji rebellion between 1905 and 1907 is one example. People in Southern Tanzania resisted German colonialization by using traditional medicine. These people, in what literally became the War of Majimaji were convinced that bullets would not harm them; instead, the bullets would change into *maji* (water) (Iliffe, 1967; Redmond, 1975). With such stories, traditional medicine became a catalyst for assurance, motivation and confidence.

DETERRENCE AND DEFINITIVE PUNISHMENT: INTERNAL SOCIAL PROCESSES

Sungusungu was used to identify criminals and to ensure that these criminals would confess at village meetings and would then pay fines and compensations. Criminals were arrested and fined based on crimes they had committed.¹⁶⁸ Though its primary goal was to ensure social order, Sungusungu also embodied an attempt to bring back traditional leadership organizations among Sukuma and Nyamwezi people. For instance, the movement employed customary laws for handling security issues and other social concerns, such as disputes concerning marriages, bequests (*mirathi*), and disputes over land and water (Nkonya, 2006). The post-Ujamaa villagization and post-war security void created conditions for people to adopt communal programs that could provide security to their lives and belongings. These security programs drew from both historical precedents and contemporary ideas.

Abrahams (1989) recalls the people in the region where he conducted his fieldwork: “Generations of ‘ordinary’ people whose main needs and concerns include the health, security, and moral and material prosperity for themselves, their families and sometimes their neighbors, as they try to make a living in a relatively unpromising environment.” These ordinary people involved in the movement were keen to adapt traditional arrangements. Such arrangements were seen as effective means to enhance social cohesion because community members were fully involved in security matters. In

¹⁶⁸ Interview, Neto Nchelege, Mahaha-Ndagalu, Magu October 16, 2009.

addition, enforcement of agreed customary laws was effective. Village members could easily identify strange things happening in their communities and would willingly share information with other village members.

Villagers had the opportunity to select their own leaders among community members they trusted. The leaders were trusted because of their knowledge of the local culture. Many community members expected the government's enforcement bodies, such as the police, to intervene whenever there were crimes. Article 14 of the Constitution of the United Republic of Tanzania states: "Every person has the right to live and to the protection of his life by the society in accordance with the law." However, for various reasons, such as lack of personnel and equipment, or corruption among officials, the people in Sukumaland felt that the government had not been quick enough to respond to their daily security issues (Heald, 2002). In some situations, members of the community felt state officials, particularly police officers and court officials, were colluding with criminals. Many community members thought that those who dealt with criminals were easily bribed, and, therefore, these officials' judgment and authority were compromised.

In order to respond to crimes and to ensure protection of properties in North Central Tanzania, Sungusungu created a "social contract" that allowed community members to establish and participate in a local communal army. This social contract was based on the recognition that communities faced threats. These threats required communal solutions. Communal solutions could be achieved through mutual consent and the creation of a set of rules and procedures. The movement attracted many other people from various communities; therefore, the scope of security issues increased. The

movement quickly spread to almost every part of central and northern Tanzania, covering Sukumaland (Mwanza and Shinyanga regions) and the Tabora region.

The adoption of the Sungusungu movement in new villages followed a particular pattern and embraced a commitment to clear neighboring villages from crimes and criminals. Every community that joined the movement had to absorb and disseminate the Sungusungu ideology to neighboring communities. As one interviewed healer noted, “We were enthroned by the (Sungusungu) army from the neighboring villages, Isoro, Ng’wamasele, the village that had undergone the process before us. We undertook secret ballots in order to identify criminals and witches, because we knew in which *balozi* (a unit for ten houses in the village) they existed.”¹⁶⁹

This approach proved effective in recruiting people from different societies at minimum cost. The use of neighboring community members (whose communities had already undergone enthronement) served three purposes. First, this usage provided assurance that the process had been successful in other villages and could be applied elsewhere. Second, such usage could demonstrate the effectiveness of other villages’ collaborative efforts to deal with crime. Third, the use of neighboring community members ensured the sharing of resources, such as medicinal knowledge, among the leaders of different communities.

The Sungusungu movement was able to expand its responsibility to cover a wide range of issues. These included: securing people’s property, livestock and crops, maintaining peace in the community, advising about social affairs, availing social

¹⁶⁹ Interview Salime Madi, Mahaha-Ndagalu, Magu October 10, 2009.

services for the community (such as well digging and cleaning), ensuring that civil servants fulfilled their obligations, and also conserving nature in areas that were protected from human activity.¹⁷⁰ Equally importantly, the Sungusungu provided a forum to deal with witchcraft and accusation issues that had been neglected by the government, despite the strong presence of witchcraft issues in daily life for many Tanzanians (Brycesson, 2010; Green, 2005, Mesaki, 2009).

Initially, the government was not sure how to respond to the Sungusungu movement because its goals were not clear. The government was ambivalent, according to Heald, especially regarding the use of traditional regalia and symbolism that was part of chieftainships in Sukumaland in the past. Government officials were worried the movement could cause conflicts between ethnic groups based on their cultures and would revive abandoned the chiefdoms (Abrahams, 1997; Heald 2002). What the government did know, however, was that Sungusungu operated outside the legal system. The government was keen to observe whether the movement had political ambitions (Abrahams 1987). Despite the knowledge that Sungusungu operated outside the legal framework, the government faced challenges when deciding how to deal with a well-organized and mobilized social movement tied to the people's concerns. The movement was allowed to continue, especially after establishing that it had no national political ambitions. Soon after its inception, the movement spread to almost every region of Tanzania, suggesting that security concerns were widespread. In addition, parts of Kenya,

¹⁷⁰ Interview, Wilson Madi, Kisesa-Magu, August 16, 2009

particularly those regions bordering Tanzania, embraced the movement (Heald 2002, 2006). The next section examines how security issues have been dealt with in Sukumaland and how the Sungusungu movement revived the traditional approaches.

SUNGUSUNGU: A UNIQUE SOCIAL MOVEMENT THAT USES TRADITIONAL MEDICINE

Traditional medicine was a symbol for legitimacy and power, and an important tool to control both internal and external threats. Based on this importance, knowledge of traditional medicine was a major criterion in the selection of Sungusungu leadership. Traditional medicines were used to empower the movement and, at the same time, weaken criminals. An excerpt below from a retired Sungusungu Chief in Ndagalu Magu, Mwanza, who was born in 1918, reveals the way in which traditional medicine was used at different stages of the movement:

I arrived here (in Nyashimba village in Ndagalu Magu Mwanza) in the early 1950s and at that time this place was mainly a forest with wild animals. That is when other people started to come. I was among the elders that were entrusted to give advice and distribute parcels of land in this village, and that was the beginning of this village, because people started here (*he indicates where his house is located*). That is why people respect me very much (*kwa hiyo watu waliniheshimu sana*). Initially, before Sungusungu, the Sukuma army was called *Kisumba*, which means the community army involving young people. In the past, there was no Sungusungu. I was their *Kingi* (*The official for security matters for the young men, mandated to supervise in the village, but literally “King”*)¹⁷¹

Traditional medicines cannot be isolated from people’s livelihood. The excerpt below indicates that medicine was an important tool to facilitate hunting and the eventual, localized, extinction of animals. These extinction incidents demonstrate the perils of

¹⁷¹ Interview, Nela Kingwa, Ndagalu Magu, October 15, 2009

traditional medicine for endangered species, particularly those used in therapies. The loss of animals used in therapies also had subsequent effects on human health.

I was taught how to use spears and arrows. I was a great hunter and people knew that; I knew a lot about traditional medicines that were used to threaten animals, and other medicines that forced animals to run away. I obtained these medicines from my father. I was also a *mgindu* – a shape-shifter. I could enter people's houses during day and night times without their knowledge; they were not able to recognize me. This is all about my secrets. (*Kwa uhodari huo*) using that expertise and skill, I managed to hunt different kinds of animals: leopards, lions, and hyenas to the extent they were extinct in this area.¹⁷²

Regardless of the environmental impact, people embraced and trusted the power of traditional medicine to deal with national security. As previously mentioned, traditional medicine had long been associated with security. The excerpt below shows the way in which one of the Sungusungu leaders wanted to use his knowledge of traditional medicine to fight in the war against Uganda in the 1970s. The respondent confided that his knowledge of medicine could have helped the Tanzanian army fight and win the war. His traditional medicine skills included his ability as a *Mgindu* (a shape shifter).

People were scared of me. In 1978 there was a war with Idi Amin of Uganda, and I wanted to go and fight. I was restricted because of my age (91 years old when interviewed). People selected to go to war were young. I felt bad when I was not selected. In 1982, I started hearing about the Sungusungu army; I was excited and eagerly waited for it.¹⁷³

Sungusungu, like any other social movement, adopted code of conduct that would differentiate them from other community members. Sungusungu developed peculiar dress that served different purposes. One such purpose was to identify members of the army to

¹⁷² *ibid*

¹⁷³ *ibid*

one another while also ensuring that those who were part of the movement were not publicly identifiable to others for security reasons. One respondent recalled:

One day while on a trip in Isoro (the village nearby to his), I was told by my host that the next day their village will be enthroned/initiated/crowned (*temiwa*). I was interested to see what was happening. I witnessed many Sungusungu armed people wearing hides and feathers in order to conceal their faces. They arrived at 8 am, and people from the entire village were sitting on the grounds of the primary school. Then came Sitta Mahende—a grandson of Ng’wana Malundi—and he was the chief.¹⁷⁴

The respondent noted that Sitta, the chief, is recognized and praised as a founder of Sungusungu in their songs. He is referred to as *Kishosha Mang’ombe ng’wana Sitta*, literally “a son of Sitta, the returner of stolen cows,” in the literature (Gunderson, 2010; Heald, 2002). In Sukumaland, Ngw’ana Malundi, the father of Sitta, is known for his magical knowledge. The respondent continued:

Then the meeting started, and people were given an opportunity to select their *Mtemi* (Chief), *Mtwale* (Assistant Chief) and *Kamanda Mkuu* (Chief Commander) and then *Makamanda wadogo wadogo* (subordinate commanders), and *Wazee wa Sungusungu* (Sungusungu elders). Then it was a turn to punish criminals who had already been identified through secret ballots. I could see like twenty individuals, including eight women accused of witchcraft and the remaining twelve men accused of cattle rustling.¹⁷⁵

Interviewed Sungusungu leaders noted that caning was a punishment and a mechanism to force people to confess their wrongdoings. The level of punishment was determined by the extent to which the accused had confessed and the compensation the accused had agreed to pay. Again, the respondent describes the process:

They (the accused) were beaten and one of the women *akajinyea* (defecated) and confessed that she was a witch and that she had magically hidden people who were known to have died. Some people demanded that she should release them

¹⁷⁴ *ibid*

¹⁷⁵ *ibid*

all, but others suggested that the task be carried out under the supervision of the people who knew traditional medicine. Other suspects were beaten and asked to bring items used in witchcraft activities.¹⁷⁶

Confession involved declaration of tools used to commit crimes. The public viewed strange materials owned by criminals. As one of the interviewed leaders noted, “We saw strange things that day; we saw bones suspected to have been extracted from humans and different kinds of materials used for witchcraft; it was the day that I will never forget.”¹⁷⁷

Interrogation, confession, and punishment were used as a mechanism to enforce Sungusungu laws. Criminals were made to declare the compensation they should offer by weighing their misdeeds. Whenever people agreed upon the suggested compensation, they clapped their hands and the *Mtwale* (Assistant to the Chief) and *Mtemi* (Chief) ordered five *makamanda* (commanders) to collect fines that were kept and managed by Sungusungu and the village authority.¹⁷⁸

Criminals were also asked to name their conspirators. After the collaborators had been identified and included in the ritual, the criminals were gathered in a large group. Sungusungu sprayed salted and peppered water on the criminals’ buttocks before they were caned in order to enhance the pain of punishment. Criminals were caned “*mpaka wakachanika matako*” (until they had sores on their buttocks) and until they declared that they would quit practicing witchcraft. One observer noted, “I was shaking; I did not know that Sungusungu operated that way! The exercise ended in the evening. Afterward we

¹⁷⁶ *ibid*

¹⁷⁷ *ibid*

¹⁷⁸ Interview, Mani Yenze, Minoang’ombe-Ng’wamashimba, Magu October 14, 2009.

ate—ten cows had been slaughtered for meat. We ate and also had a lot of meat left over.”¹⁷⁹

A person’s qualification to become a leader in the Sungusungu movement was based on the popularity of their traditional medicine, as the excerpt below shows:

I asked my host ‘why have they selected you to become a *Kamanda* for Sungusungu (Commander for Sungusungu)? And you agreed!’ He responded saying, ‘People know that I am the healer and I know medicine because I treat people here. That is why Sitta (*assumed here to refer to the founder of the movement*) identified me because he knew me, and he is also the chief in this zone of Ndagalu, and that is why I agreed.’ That is when I realized that this work requires somebody who knows and practices medicine. Without that, the entire army may perish by being bewitched, and it is not an easy task to punish witches. That is why I was worried that when they arrived to our place, I would definitely be selected to be a leader.¹⁸⁰

The use of secret ballots suggests that criminals are known in societies. A similar strategy of secret ballot was recently used by the state to name criminals and those suspected for violence against people with albinism. The respondent continued noting how Sungusungu was embraced in his village:

It did not last long (*few months later*) after witnessing the event in our neighboring village; we received a letter in our village that we should get prepared. Our village would be next to be crowned. We had to organize a meeting and conduct secret ballots to identify criminals (*bandits and witches*). The suspected criminals, identified by secret ballot, were to be announced at the village meeting. The chairman convened the meeting, and he selected me *Kingi* to supervise the exercise.

People voted for almost a week at the village office to identify witches and other criminals. We reviewed and sorted the votes to determine who received many votes. We listed people who were voted as criminals and there were about thirty names representing bandits and witches. That is when we called another meeting to *kukusanya mboga* (collect cows for meat). We collected eight cows from different individuals who volunteered to support the event. That is when we sent a message to Sitta (*the renowned leader who has participated in similar events in many other places*), who came with his army (*basalama*) to crown our village.

¹⁷⁹ Nela Kingwa, Ndagalu Magu, October 15, 2009

¹⁸⁰ *ibid*

The election exercise started and people were asked who do they want to be their chief, some names were given and my name emerged. I was crowned and given *upinde na mishale na mkuki vimepwakwa dawa za jadi* (a bow, arrows, and spear that were treated with traditional medicine). I was also given *fimbo* (a wooden bat) treated with medicine (*imepakwa dawa*). I was told that whenever we sit to decide on anything, I will need to have the bat treated with medicine. We selected the *Mtwale* (Assistant to the Chief) and *Makamanda* (Commanders).

Thereafter punishments for those accused of witchcraft and theft started. I was surprised to hear a woman confessing that she killed one of my relatives through witchcraft. This was when she was asked to confess about other people she had killed in the village. The accused were taken to their homes in order to bring back items used for witchcraft. The materials used for witchcraft were brought and burnt.¹⁸¹

Sustaining the movement involved devising a strategy to ensure the mobilization of resources. Fines and compensations paid by the convicts were used to support different activities of the Sungusungu movement. After bandits were fined and caned, the respondent continued:

On that day the village managed to collect fifteen cows as fines. The village decided to have a ceremony for the achievements made on that day. Cows were slaughtered and meat was cooked for all people in the village to eat. That was the end events for that day and I will never forget it. That is when I started the task as the chief of this village and was mandated to deal with criminals such as cattle rustlers. We could punish people who stole cows in markets and we were able to control witchcraft activities.¹⁸²

The above excerpts from interviews show the way in which traditional medicine was necessary to ensure that the Sungusungu army was protected from different kinds of threats, such as witchcraft and robbery. Another interviewed healer emphasized the importance of medicine, saying, “Without medicine it is hard to deal with witches and

¹⁸¹ *ibid*

¹⁸² *ibid*

bandits - that is why there are bandits roaming around freely and nobody is able to deal with them. I am appalled by the government intervention to disrupt Sungusungu.”¹⁸³

For Sungusungu, traditional medicine plays a role similar to that played by chemical weapons for warfare and security purposes. Yet, the literature has rarely covered the relationship between traditional medicine and security affairs. Though traditional medicine has less impact on global security affairs, it plays a significant role in internal security affairs. The use of magic in the fields of witchcraft and traditional medicine is both a threat and a blessing. People in communities are worried about invisible forces related to witchcraft and tend to use protective traditional medicine. Traditional medicine is a part of people’s cultural identity, an important tool used to deal with both natural and human induced ailments that could compromise stability and security of a family and society. The use of traditional medicines was an integral part of Sungusungu community actions.

Traditional medicines are known for curing illnesses, particularly when the body’s defense mechanisms are compromised. Similarly, crimes may be views as ailments that may have pronounced effects on a defenseless community, or body of people. The invisibility and secrecy behind witchcraft make it difficult for people to trust their individual protections; instead, they feel compelled to rely on communal efforts, such as those employed by Sungusungu.

¹⁸³ Interview, Bonika Bungi, Nyasato Ndagalu, October 15, 2009.

Whereas the government reluctantly dealt with witchcraft, Sungusungu prioritized it. More often than not, the legal framework complicated trials related to witchcraft. The punishment of individuals who kill alleged witches created a conflict between state legal norms and the norms underlying popular beliefs. Theoretically, disputes that involve witchcraft are dealt legally with by the Witchcraft act. Practically, the act is not enforceable (Diwan, 2004). The law concerning witchcraft is less familiar and accessible to the community it was meant to serve. This reality, essentially, rendered the law ineffective (Diwan 2004). The failure of the judicial system to deal with witchcraft gave Sungusungu an opportunity to challenge or complement government statutes that were incapable of insuring the security of its people. Sungusungu dealt with many more cases of witchcraft than the police. Traditionally, the antidote for witchcraft has been divination and traditional medicines; these are among the core practices of Sungusungu. The government restriction of divination, a practice believed to perpetuate violence, hindered the effectiveness of Sungusungu when dealing with criminals. As shown in chapter one, traditional healers see divination as important component in health and security affairs.

The use of traditional medicine by Sungusungu involved selecting leaders who were knowledgeable in the field of medicine. Leaders had to have a strong knowledge base to outwit criminals (robbers and witches) who use protective medicines themselves to carry out their crimes. Sungusungu leaders prescribed medicine to members of its army to protect them from harm by criminals during the enthroning/crowning (*kutemiwa*) exercise. This exercise was also crucial to combat crimes and to purge societies of people

practicing witchcraft.¹⁸⁴ Traditional medicine was used to respond to different forms of countermovements directed against Sungusungu. In this role, traditional medicine gave protective assurance to the participating members that they would be safe from threats caused by criminals.

The prevailing fear for criminals was that Sungusungu medicines could penetrate any protection criminals may have used; therefore, they were afraid their crimes could not be concealed. As part of the procedural mechanism in an investigation, suspects swore they would be candid in their confessions. Sungusungu used traditional medicines at different stages during these investigations. Rituals involving traditional medicine were done at every enthronement event. Enthronements also involved the use of secret ballots to identify criminals. Protective medicines and physical camouflage were also used to conceal the identity of people in the army in order to avoid retaliation from criminals. In some situations, Sungusungu mercenaries from neighboring villages were hired to punish criminals in a newly enthroned village to insure community members were safe from retaliation and revenge.

At the same time, traditional medicine became a self-regulating mechanism to maintain the social order within Sungusungu. Members had to swear that they would not expose the secrets of Sungusungu. The medicine for those taking the oath served two purposes, fear and confidence. Sungusungu members feared punishment if they exposed secrets and knew they would be punished. However, because of the protection it

¹⁸⁴ Interview, Neto Nchelege, Mahaha-Ndagalu, Magu, October 16, 2009.

conferred, the medicine also gave members confidence that they would have strength and protection when fulfilling the responsibilities of the movement (Nkonya, 2006).

In all the detailed interviews I conducted with ten Sungusungu leaders, all but one had become leaders based on their knowledge of traditional medicines. This knowledge was confirmed by interviews of more than thirty healers in Mwanza, all of whom acknowledged the importance of traditional medicine for the Sungusungu movement. Selected leaders had to demonstrate traits, such as self-esteem, confidence and follower values, and intrinsic motivation. Although some of these characteristics are inborn, Sukuma people believe that some of them can be enhanced by the application of traditional medicines. Traditional medicines were also used to improve desirable traits for the selected leaders to increase their trust and loyalty among members of the community. According to Stroeken (2001) such a recipe of attraction in Sukumaland is famously known as *samba* (attractive medicine). Therefore, rituals for leadership selection also involved the use of traditional medicine to affirm authority and power for the persons identified as leaders.

The groups that conducted enthronement tasks had to ensure that they were installing leaders who could fulfill the objectives of Sungusungu. Leaders were expected to maintain security and harmony within the community, and to create and maintain good relationships with neighboring villages. However, Sungusungu leaders, when asked how they benefited from their positions, noted that, generally, the benefits among individuals were insignificant compared to security benefits brought to the communities. They stated they received a small share from fines or compensations from criminals. Whenever a criminal paid a fine, the amount was divided in such a way that a small amount was used

to maintain the offices for *makamanda* (commanders). The remaining amount was directed to the *Mfuko wa Sungusungu* (Sungusungu bank account). That money financed activity related to criminal investigations and arrests.

The use of magic medicine for security and politics is not a new phenomenon in Sukumaland. During the chiefdoms era, chiefs consulted diviners to determine the fate of their administration. Likewise, chiefs had to maintain the stability of their constituency in the face of both internal and external threats. Chiefs who lost their constituencies were considered weak. Those chiefs would have to relinquish power to others who were seen as more competent to govern. Security among Sukuma people comprised production of enough food. Therefore, chiefs and their subordinates worked with diviners and rainmakers to ensure conditions conducive to food production and livestock keeping. When conditions were bad, chiefs instructed diviners to consult their spirits to determine the reason for those conditions and to ask what actions to take to change those conditions. Such actions included the performance of rituals to appease spirits in order to bring rain to support farming (Nkonya, 2006). Sungusungu drew from these traditions among chiefdoms and performed medicine to ensure social cohesion, security, and stability.

The use of traditional medicine was also used to pursue and deal with criminals who used protective medicine.¹⁸⁵ Members of Sungusungu were aware that criminals often used medicine to execute their criminal acts. These kinds of medicine were used to empower the criminals and to distract victims. Criminals used medicine to remain invisible to their victims so that they would not realize crimes were being committed. Criminals used other medicines to protect themselves from arrest and, on some occasions,

¹⁸⁵ Interview, Mani Yenze, Minoang'ombe-Ng'wamashimba, Magu, October 14, 2009.

to escape prosecution. Some criminals used medicines to prevent prosecutors from finding evidence. This lack of evidence would force prosecutors to set the criminals free. Sungusungu leaders were obliged to have superior knowledge in traditional medicine to counter any effects of criminals and people practicing witchcraft. Leaders used neutralizing medicines as power to help criminals confess their wrongdoings, agree to pay compensation, and promise not to commit crimes in the future. According to the interviewed individuals, medicine also ensured that bandits would reveal what they had stolen, which specific weapons they had used, where they had kept the stolen materials, and who their collaborators had been.¹⁸⁶ Paciotti notes:

The highest-ranking leadership positions include a chief (*ntemi*), followed by a chairman (*mwenyekiti*). The chief is expected to use his knowledge of divination to protect those under his command and to identify suspected deviants. The chairman is usually a charismatic public speaker able to effectively lead public meetings, as well as control members when heated. Experiencing similar problems under a weak state, different Tanzanian ethnic groups and urban population have not been equally successful in creating and sustaining institutions of social control such as Sungusungu. (Brian Paciotti).¹⁸⁷

The power of the leaders was associated with charisma, knowledge and skill in traditional medicines, as well as their magical capabilities. For example, a *Mtwale* (Chief) for Sungusungu I interviewed stated: “My major task is to use my ability in traditional medicine to protect my army. Therefore, whenever there is a big issue to deal with I have to do something, especially when we have to deal with witchcraft, because that is the big

¹⁸⁶ Interview, Malasi Chani, Nyasato- Ndagalu, Magu October 14, 2009.

¹⁸⁷ Source: <http://www.anthro.ucdavis.edu/faculty/monique/MBMWeb/MBMData/Paciotti.pdf>

and threatening aspect. Therefore, protective medicine is very important, and personally I know a lot of things (about traditional medicine).¹⁸⁸

People involved in an enthronement exercise had to undergo rituals that were undertaken under the supervision of the *Mtemi* (chief) and *Kamanda* (commander). These rituals ensured the safety of the army and those people who participated in pursuing and punishing criminals. If a particular community lacked a charismatic leader, even though the *Mtemi* was knowledgeable in traditional medicine, recommendations could be made to locate a charismatic individual from a neighboring village who was competent in the field of traditional medicine. Identified individuals were recruited to administer Sungusungu activities in territories that were not theirs. This recruitment of charismatic leaders was done to increase trust and confidence among participating community members in the Sungusungu movement. The strength of the leaders was important. They had to deal with invisible threats that could not be dealt with by government institutions, because these institutions did not believe in witchcraft. Leaders had assigned responsibilities to go to other villages to negotiate or to participate in enthroning activities. The collaboration between villages and movement of leaders between different areas was effective to ensure safety in a wide area because knowledge of criminals and their activities would become wider known.

The hierarchy of Sungusungu involved decision makers and enforcers of laws (Abrahamas, 1987; Bukurura, 1995; Heald, 2005; Nkonya, 2006; Picott, 2004) For

¹⁸⁸ Interview, Mani Yenze, Minoang'ombe-Ng'wamashimba, Magu, October 14, 2009

instance, the Ntwale also had an advising group of elders called *Banamhala ba Ntwale*. The *Katibu* (secretary) recorded and kept documentation of all activities and meetings happening in the village. A Chief Commander (*Kamanda Mkuu*) oversaw security operations undertaken by the Sungusungu army. He was the one in charge of daily operations, such as arresting, prosecuting, and conducting trials of the criminals at the meetings. Assistant Commanders, known as *Makamanda wasaidizi*, support the chief commander. A group of young people carried out daily operations; they were referred to as *askari* (soldiers). Soldiers tracked down suspects and criminals, conducted patrols in the community, investigated offences, and solicited evidence and witnesses. In addition, the Sungusungu contained ordinary community members who were expected to attend the meetings.

Knowledge of traditional medicine was the foremost qualification for the Chief Commander (*Kamanda*) and the Chief (*Mtemi*). Without traditional medicine, someone could not lead Sungusungu.¹⁸⁹ Another interviewed leader noted that a *Mtemi* (Chief) was supposed to be a person with sound knowledge in traditional medicines. He and his subordinates, the *Kamanda* (Chief Commander) and the *Mtwale* (Assistant Chief), were supposed to be competent in traditional medicine. Some of the selected leaders came from families that were known to practice witchcraft.¹⁹⁰ The process of enthronement involved rituals performed by the individuals involved in the exercise:

Before going to an enthronement (*temya*) in other villages, all soldiers were asked to visit the *Mtemi* in order to undergo a ritual (*kuzindikwa*) that was executed by both *Mtemi* and *Mtwale* that allowed you to go to another village. This exercise was for protection and the assurance of safety. Protection was

¹⁸⁹ Interview, Salime Madi, Mahaha-Ndagalu, Magu, October 17, 2009.

¹⁹⁰ Interview, Simane Mala, Nkunguru-Ndagalu, Magu, October 18, 2009.

necessary to avoid threats and to return home safely. That is when you affirm that you have a strong leader, that is *Mtemi* and his subordinates have power based on their medicinal knowledge.¹⁹¹

Traditional medicine had other roles in galvanizing cohesion among participating members. The power as well as the authority of the movement was determined by factors such as regulation, expert knowledge, and networking ability. To create cohesion, every leader and army member was given traditional medicine (Heald, 2002). All community members were expected to participate in the movement. However, despite the inclusion of many people in the Sungusungu movement, not all members of various communities chose to participate. Many of them worried that a failure to participate in the movement would invite punishment during rituals conducted in the village. Conversely, participating members felt assured that they were guided and protected by medicine and that they were not at risk in the community. Furthermore, those who participated felt that they would be safe from threats that did target those who failed to participate.

Interviewed personnel have also lamented that the system that was used to select charismatic and effective leaders had changed. For example, the effectiveness of Sungusungu in contemporary settings has declined due to the limited use of rituals and traditional medicines. Leaders who are selected now are not necessarily competent in the field of traditional medicine as it was in the past:

The use of medicine was necessary especially during enthronement, it was imperative to have a *Mtemi* and *Mtwale* knowledgeable of medicine, but now days these aspects have been abandoned and there are no enthronement practices as they were done in the past. I am not sure even now, even though our *Mtemi* knows about medicine, but maybe he uses them secretly in his office, because I

¹⁹¹ Interview, Neto Nchelege, Mahaha- Ndagalu, October 16, 2009.

have not seen the use of medicine publicly in our Sungusungu. In the past Sungusungu could hardly be separated from traditional medicine.¹⁹²

While traditional medicine had been instrumental in sustaining the Sungusungu movement, reciprocally, the movement gave legitimacy and autonomy to traditional medicine and its actors. The era in which the Sungusungu movement was created was also the period in which traditional medicines were revived in a political context following their denigration by colonial and independent governments. Healers themselves saw the Sungusungu movement as an opportunity to revive and legitimize their history, culture, beliefs and traditions. The movement gave a voice to healers, who had become a marginalized group. Sungusungu also demonstrated that traditional medicine is not only about health of the body and mind (Du Toit 1971). Instead, traditional medicine deals with the health of the society to promote freedom from societal illness. Thus, the use of traditional medicine demonstrates how the power of the medicine influences social and political structures. The use of traditional medicine for security was publicly accepted despite people's ambivalence about using traditional medicine in health programs. People remain ambivalent about the use of traditional medicine in health programs. Its use has been challenged because it lacks standards.

Within communities, the use of traditional medicine helped build trust that their leaders were capable of dealing with threats. The decline of the use of traditional medicine by the Sungusungu movement is linked to its weakness in meeting society

¹⁹² Interview, Neto Nchelege, Ndagalu-Magu, October 19, 2009

security affairs. Consequently, the decline of locally governed security systems in communities is considered one reason for an increase in crimes (such as the spate of albino killings that dominated local and international press over the past three years that is covered in detail in the next chapter.

POLICING: DEALING WITH CRIMINALS

The Sungusungu army dealt with different groups of criminals such as robbers, witchdoctors, people who attacked the elderly with witchcraft accusations, people who committed adultery, and people who engaged in sexual relationships with students and minors. Sungusungu dealt with these issues differently than did the police force. More often, police responses to crimes were reactive and involved investigations, arrests and prosecutions. Sungusungu used both proactive and reactive measures to prevent and deal with crimes. They exposed suspects within communities, forced criminals to confess past criminal records and then fined these criminals.

INTERROGATION, CONFESSIONS AND PUNISHMENT

During Sungusungu community meetings, suspects identified by secret ballots collected from community members were asked to confess their criminal activities related to witchcraft. Use of a secret ballot was not a new phenomenon; rather, it was a system inherited from a traditional security system. As one of the Sungusungu leaders, noted, “It (a secret ballot) originated from our fathers and grandfathers; this was the system widely applied to deal with *balogi* (witches) and *wiguliji* (people opening doors at night with intent of raping sleeping women) and *bugindu* (shape-shifters who use magic

to enter houses to steal food, sheep and goats.) The procedure to deal with suspects entailed interrogation, confession, and punishment.”¹⁹³

Confession was the strategy most often used to correct criminals’ behavior. Confession sessions were done at the village open meetings. Committees further scrutinized the identified suspects to ensure that those who had been labeled criminals were truly guilty. Sungusungu leaders would invite nominated elders into the movement to seek their advice concerning criminal suspects. Elders made recommendations about the way in which criminals should be handled, according to the punishment and fines meted out. The committee then discussed the names of suspects. Some identified suspects were given an opportunity to confess their wrongdoings. Depending on the nature of the problem, some suspects were forgiven while others were punished. Those who resisted confession were ostracized.¹⁹⁴ Along with confession, criminals were expected to surrender materials used to commit crimes and witchcraft, compensate victims, and vow to refrain from further crimes. These acts were considered part of a “cleansing process” that gave individuals another chance to live within the society (Diwan, 2004).

The Sungusungu movement had different punishments for different crimes. For example, witchcraft activities received more severe punishment than crimes related to robbery, cattle rustling, and adultery. Nkonya relates the process:

Punishment imposed by Sungusungu range from fines to ostracism, and to eviction from the village. Offenders, who are brought to Sungusungu, plead guilty and confess their wrongdoings are fined. Those who refuse to confess or pay the fine face ostracism. Sungusungu uses ostracism for two major reasons: first to punish the offender and second to make the offender confess and correct

¹⁹³ Interview, Mani Yenze, Minoang’ombe-Ng’wamashimba, Magu October 14, 2009

¹⁹⁴ Interview, Mani Yenze, Minoang’ombe-Ng’wamashimba, Magu October 14, 2009

their behaviors to conform to customary norms, and becoming “*nsalama*” or a person of peace (Nkonya, 2006; p.152 154)

Different punishments for different crimes were also determined by gender. Exclusion from leadership and decision-making processes put women living in Sungusungu areas at a disadvantage. In such a situation no one defends women’s rights or their positions in society. Women are more likely to be accused of and punished for witchcraft; elderly women are the most targeted group. More women were accused of being witches in the region during both the pre-Sungusungu period and at the time of Sungusungu than during the present era (Mesaki, 2009). Over the years, women accused of practicing witchcraft were treated more harshly in comparison to other criminals. In one of the villages, for instance, witches were asked to bring four cows as compensation, whereas bandits were asked to bring one cow.¹⁹⁵

Women often died from the severity of their punishments, whether they were caned or ostracized. Women are less likely to challenge injustice in societies that are dominated by males, particularly in matters related to witchcraft. More often than not, women accused of witchcraft by Sungusungu ballot remained passive; those who responded differently were considered deviants and punished more severely.

While women were accused of being witches, men were more likely to be accused of robbery, banditry, and brigandage. This distinction shows how societies define crimes along gender lines. The disparity of punishment and compensation between witches and bandits suggests that the Sungusungu had a witch-finding mission (Heald, 2002). The

¹⁹⁵ Interview, Neto Nchelege, Mahaha-Ndagalu, Magu, October 16, 2009.

disparity was exacerbated by unequal outcomes, by gender, for the same action. While women may have been accused of witchcraft, men who practiced witchcraft may have been praised as conquerors and bringers of order, and may have even been selected to become Sungusungu leaders.¹⁹⁶

The accusation of witchcraft against women in villages does not match with the number of accusations of sorcery related to witchcraft. For instance, no woman was accused, arrested, prosecuted or jailed in relation to the albino murders that were committed in order to sell their body parts for occult and witchcraft purposes. In the three court rulings reviewed that dealt with albino killings, none of them indicated the involvement of women.

SUNGUSUNGU SEEKING POLITICAL LEGITIMACY

Sungusungu shared traits central to social movements. As a social entity it strove to ensure its legitimacy and to quash threats that would destabilize the group. After achieving those objectives, Sungusungu adopted strategies to assimilate mandates and to establish a role within of the law enforcement community in Tanzania, without relinquishing its power. Sungusungu used different strategies to position itself as a recognized organization that helped communities secure order and safety, including efforts to formally institutionalize Sungusungu by reasserting public authority (Ho, 2010). The establishment of Sungusungu altered the landscape of political structure and security issues in the areas where they operated. Although Sungusungu was challenged

¹⁹⁶ *ibid.*

for taking the law into its own hands, the movement was also praised for maintaining social order in communities. The former president, the late Mwalimu Nyerere, and the former Prime Minister, the late Edward Moringe Sokoine, were the first government officials to endorse the Sungusungu movement. Their approval was vital for the survival of the organization despite its operation outside the legal structure. The government itself acknowledged that levels of crimes were relatively low in all places where Sungusungu existed (Heald, 2002). The level of success forced President Nyerere to sanction activities undertaken by Sungusungu.¹⁹⁷ People trusted the movement. Because of its success, people believed that the movement was permanent and would become legitimate and would be given a routine mandate to address crimes (Ho, 2010).

Sungusungu collaborated with village administrations as a coalescing mechanism to justify their activities and their autonomy. Sungusungu as a movement also sought legitimacy by working collaboratively with government enforcement agencies that had a role in protecting people's lives and property. The presence of Sungusungu formed complementing and antagonistic relationships between government and personal security measures. In some situations, Sungusungu collaborated with the police to deal with crimes by exposing, arresting, and handing over the suspects to the police for further investigation and prosecution. In return, the government provided armed forces to support Sungusungu when dealing with criminals, particularly in those communities where

¹⁹⁷ Crime and Policing in Dar es Salaam Tanzania Focusing on: Community Neighborhood Watch Groups – ‘SungusunguSungusungu’ Paper presented at the 1st Sub Saharan Executive Policing Conference International Association of chiefs of Police (IACP), Durban, South Africa: 27 – 30 August, 2000 accessed January 4, 2011 from http://www.unhabitat.org/downloads/docs/1825_12883_Sungusungu.pdf

locals were challenged by a lack of skills and equipment to deal with armed criminals. While government agencies did not acknowledge or deal with witchcraft, locally initiated security programs filled the void. However, despite collaborative efforts with state enforcement agencies, Sungusungu leaders were accused of violating the Tanzanian constitution by taking the law into their own hands and punishing suspects to death. Such actions have weakened and delegitimized the movement in more recent years.

Social movements can influence policy, alter political alignments and raise the public profile and salience of particular issues. The success of Sungusungu is evident by the change in laws that gave Sungusungu partial authority to deal with criminals. Sungusungu demonstrated efficiency in dealing with security affairs to the extent that it drew political and media attention. Recently, Prime Minister Mizengo Pinda acknowledged the importance of Sungusungu when he suggested that Sungusungu should be involved in dealing with the problem of albino killings that had occupied the front pages of the local and international press for three years (2007 – 2010). Indeed, Sungusungu strategies, such as the use of secret ballots, were recently used in identifying criminals involved in violence against albinos.

SUNGUSUNGU AND ITS LEGAL MANDATE

Despite the acknowledgement of its existence and its success in curbing crimes, ten years passed before Sungusungu was partially recognized through the People's Militia Laws Miscellaneous Amendment Act, 1989 (No.9 of 1989). The Act stipulates that the major objective function of Sungusungu is to protect people and their property within the United Republic of Tanzania, and, in order to fulfill this function, certain

members of Sungusungu were granted the power of arrest without warrant: These members were granted powers to arrest people on reasonable suspicion of them having committed a crime or suspicion that someone was about to commit a crime. Additionally, these members had the powers of search and seizure of any property found in possession of a suspect that forms material evidence of a crime that was or was about to be committed. Sungusungu is entrusted in the Ministry of Home Affairs. Section 4(1) of the People Militia Laws (Miscellaneous Amendment) Act, 1989 that stipulates: “The Minister may make regulations for effectual and smooth operation of Sungusungu in discharge of the functions under the Act.” However, to date no such regulations have been made.¹⁹⁸

Sungusungu collaborated with government authorities to deal with crimes in many different ways. There are numerous incidences that show the government embraced the attempt by Sungusungu to build trust among the people and the government. The formal incorporation of the movement was realized through the leaders who were involved in the decision-making processes. Police forces encouraged the leaders of Sungusungu to work with them to identify criminals, provide the labor force to capture the criminals and to track records related to the crimes committed by the suspects.

Despite this acceptance by the public and officials over the years, the institutionalization of the movement was hampered by legal conflict. The stability of the movement was also impacted by affected accusations of the use excessive force when

¹⁹⁸ Crime and Policing in Dar es Salaam Tanzania Focusing on: Community Neighborhood Watch Groups – ‘SungusunguSungusungu’ Paper presented at the 1st Sub Saharan Executive Policing Conference International Association of chiefs of Police (IACP), Durban, South Africa: 27 – 30 August, 2000 available at http://www.unhabitat.org/downloads/docs/1825_12883_Sungusungu.pdf

dealing with criminals. The controversy over dealing with witchcraft was another point at which Sungusungu faced differences with the government. While Sungusungu believed it was addressing the problem, the government's stance was as there was no proof to convict and punish people suspected of practicing witchcraft. These conflicts have caused the decline of power of Sungusungu. Despite legislation that was introduced to support the activities of Sungusungu, the movement has been weakened.

COUNTERMOVEMENT FOR SUNGUSUNGU

Social movements like Sungusungu have had to acknowledge the attempts made by the central authority to weaken people's struggle for change. The interviewed respondents noted that, despite success attained by Sungusungu in the past, there were countervailing forces that emerged both inside and outside the structure of Sungusungu. These countervailing forces destabilized the structure of the movement. Social movements are also, according to Zald (1979), susceptible to induced conflict in which factionalism, jealousy, and suspicion occurs among participating members. The Sungusungu movement was not immune to interference that emerged among its members. For instance, members of the Sungusungu, particularly leaders, were accused of squandering resources and of stealing properties that were owned by the movement. These actions, consequently, destroyed the base of the movement.

More often social movements disrupt existing structures, causing grievances, and consequently leading to a countermovement that reframes the movement's strategies. Zald and Useem (1987, pp. 247-48) note, "Movements of any visibility and impact create the conditions for the mobilization of countermovement."

The Sungusungu social movement in this part of Tanzania entails a struggle between people and criminals, while at the same time acknowledging the conflicts with security agencies, such as the police. Members of Sungusungu have been apprehended, remanded, and prosecuted, conditions that have destabilized the movement from the outside. To succeed, the Sungusungu movement had to acknowledge the presence of other countervailing forces while simultaneously fulfilling its goals. Sungusungu has been praised for improving security in the country, but the surge of Sungusungu as a social movement attracted the attention of and further scrutiny by the government:

The groups have apparently been successful in restoring a good level of security and order to the countryside, though this has occasionally been achieved at the cost of rough justice and the harassment and alleged torture and murder of some suspects. Naturally enough, such behavior has deeply worried the legal and administrative authorities. Within the villages themselves, however, the groups' activities are well supported, since those they attack are generally perceived as criminals. Also the inclusive pattern of their membership within a village gives them a strong basis of legitimacy. Sungusungu groups pose both a challenge to and criticism of the official governmental law-and-order system. (Abrahamas, 1989)

The movement was judged illegal for using harsh punishments that violated the Tanzanian Constitution and Charter for International Human Rights, especially when dealing with criminals. Therefore, Sungusungu has been subjected to social countermovements. The existence of Sungusungu in Tanzania changed the dynamic of security matters:

'Sungusungu' vigilante groups throughout the Nywamwezi and Sukuma region, provide an alternative system of 'law enforcement' which many elements in national government find challenging and worrying (Abrahamas, 1989)

Opponents have characterized punishments by Sungusungu as torture because suspects were not given an opportunity to defend themselves. In addition, Sungusungu

faced criticism because it interfered with tasks executed by the police force and judiciary system in Tanzania. Police often had to address issues caused by Sungusungu, as noted by Heald (2002):

From the beginning, however, this support did not preclude the opposition of other wings of the government, most especially of the police and the judiciary. Clearly, their actions constituted a 'taking of the law into their own hand' and were outside the law, especially as, at the beginning, there are said to have been many deaths as well as severe beatings. Further, they directly undercut the very rationale of both. More cynically, one could say that both police and judiciary found not only their role pre-empted but also the graft that accompanied it. They acted swiftly in many areas in attempts to suppress these groups through prosecutions.

On several occasions, Sungusungu representatives were arrested and accused of attacking people for no reason, and of violating people's civil liberties. The tension between Sungusungu representatives and police forces is revealed in an excerpt from an interview with one of the Sungusungu leaders in Mwanza.

Initially we collaborated well with the police, we consulted police and they allowed us to arrest and penalize criminals, but not nowadays if you (Sungusungu people) capture criminals you might find yourself arrested and remanded. There is no collaboration at all (between Sungusungu and police). You will find nowadays that bandits prefer to be dealt with by village offices; we do not have any authority with cases, unlike how it was in the past.¹⁹⁹

Thus, the Sungusungu movement faced both internal and external opposition and resistance. Some people involved in Sungusungu were consciously driven by the objectives of the organization to secure order and security through collective action. This group was willing to dedicate resources and time to fulfill the objectives of the

¹⁹⁹ Interview, Bonika Bungi, Nyasato- Ndagalu, October 15, 2009

movement. However, another group includes people who participated out of fear that they would look unsupportive of the movement. This group feared being ostracized and punished for a lack of collaboration.

When one of the members was not willing to cooperate, he would be isolated, or ostracized; this ostracized person was not allowed to participate in communal activities, nor was anyone in the community allowed to visit or work with the ostracized person. Another aspect that facilitated obligation to the movement was the subjugation of communities through the use of rumors. Rumors warned that those who were caught committing crimes would be tortured or harmed by the traditional medicines used by the movement. The resistance to Sungusungu also came from village authorities who rejected being enthroned. These authorities suggested that Sungusungu activities were disrupting the existing social structure and were hijacking local government representatives.

SUNGUSUNGU IN THE CONTEMPORARY SETTINGS

Despite its ability to reduce crime, government law enforcement accused Sungusungu leaders and armies of violating the laws of Tanzania. Consequently, Sungusungu officials were arrested, prosecuted, and jailed. These actions restrained some members from participating in the movement. As a result, enforcement of Sungusungu justice against criminals declined. Both the public and criminals became aware that the Sungusungu movement was not legally empowered to adjudicate crimes. Suspects, whenever apprehended by Sungusungu, challenged the legality of their arrest:

In the past people knew less (*zamani ujuaji ulikuwa kidogo*), but nowadays people are very much aware (*watu ni wajuaji mno*). In the past the apprehended suspects were punished to confess; it is not like that nowadays. Because today

people have gone to school that is why Sungusungu of today is about talking; and caning is no longer applied.”²⁰⁰

A respondent in Ndagalu, Mwanza noted, “There are no canes nowadays, because if you do that then you might find yourself in jail. Today we belong in a security committee (*Leo tupo kwenye kamati ulinzi na usalama*). If we cannot deal with criminals; we just call the police.”²⁰¹

The Sungusungu army in Tanzania was ordered to follow rules of the country following their involvement in the caning of three primary teachers who were punished for not attending a meeting that was organized by Sungusungu. This is one of the incidences in which Sungusungu was accused of committing crimes; however, there are other incidences that were unreported. A newspaper reported that there were about 19 families with a total number of 100 people in Ipililo village, a Maswa district in Shinyanga, whose houses were set ablaze by Sungusungu who claimed that family members were involved in crimes.²⁰²

The government, through the Prime Minister’s Office in January 2009, recommended reviving Sungusungu to collaborate with police in controlling the rash of albino killings that had been recently reported in Tanzania. This call by the government indicates that the movement is not as strong as it was in the 1980s and 1990s. The Prime Minister acknowledged that the Sungusungu helped abate crimes in the 1980s and 1990s, although the Sungusungu was stopped due to legal conflicts.²⁰³

²⁰⁰ Interview, Msela Kila, Ndagalu-Magu Mwanza, October 16, 2009

²⁰¹ Interview, Mana Ganda, Ndagalu-Magu Mwanza, October 16, 2009

²⁰² Source: *Sungusungu zingatieni sheria za nchi* (Sungusungu adhere to the state laws) (*Tanzania Daima*, Thursday May 20, 2010)

²⁰³ Source: United Republic of Tanzania Prime Minister’s Office “Pinda ataka sungungu ianzishwe upya kukabiliana na mauaji ya albino na vikongwe” at <http://www.pmo.go.tz/newshatml.php?page=341>

The call to revive Sungusungu has been received with skepticism, particularly by people who participated as leaders of the Sungusungu movement. The interviewed personnel noted that the government had restricted Sungusungu because they were interfering with the formal legal system. The police force had threatened leaders and members of the Sungusungu army. A respondent in Magu Mwanza noted that Sungusungu is not operating freely; whenever it decides to attend to concerns for people in villages, the government intercepts and disrupts the Sungusungu operations. Movement supporters say the lack of security in communities has triggered more crimes, such as the recently reported incidents of violence against people with albinism (covered in detail in the next chapter.)

Despite reported conflicts, the fieldwork in Mwanza indicates that Sungusungu is sporadically involved in security affairs. As noted in crime reports in Sukumaland, Sungusungu people worked collaboratively with the police to arrest suspects alleged to have been involved in the murder of a resident in Kilimbu village (*Republic v. Joseph Lugata*). This case demonstrates Sungusungu represented members of the community in its attempt to arrest the suspects. In this incidence, Sungusungu traveled to another village (Kagongwa-Kishima) where the suspect was believed to be, and managed to arrest the suspect and escort him to the police station in Kagongwa. In addition, Sungusungu collaborated with the police in the search for evidence at the suspect's house. Recently, the *Dailynews* reported that Sungusungu members, in collaboration with villagers in Ichwankima village in Kagera region, surrounded and lynched four suspected cattle rustlers. According to the Regional Police Commander, the suspected robbers were

burnt beyond recognition.²⁰⁴ The government has strongly challenged Sungusungu actions that are beyond the law. These actions and the challenges they have created are, for the most part, the reasons for friction with the police.

CONCLUSION

The chapter has described how Sungusungu emerged within communities as a social movement and reveals how traditional medicine was a major influence on social change in vigilantism. The chapter has also shown that traditional medicine is more than the confined definition of health and medical care; rather, it entails security affairs for the health of the communities. Sungusungu emerged as one of the largest self-organized movements in the country since the first revolts against colonialism in the late 1800s. Historically, Sukuma people have survived by organizing groups who worked collaboratively on farms for security, funerals, weddings and for other community issues (Abrahamas, 1989).

Sungusungu embraced and imitated traditional security systems by which people organized themselves to deal with threats such as disease, war, and conflict in communities. Diseases, wars, lack of food, robbery, and witchcraft practices compromised security in Sukumaland. These security aspects were the outcomes of both local and international affairs that have combined to create social conditions for local communities.

²⁰⁴ Source: Sunusungu lynch suspected cattle rustlers, four drown (*Dailynews* Online at <http://www.dailynews.co.tz/home/?n=18406&cat=home> accessed September 18, 2011)

The Sungusungu movement became a social space that allowed traditional medicine to enhance social cohesion in communities that affiliated with the movement in order to maintain security. The establishment of Sungusungu reclaimed the identity and autonomy among Sukuma people. The movement also empowered traditional healers who became new political actors and leaders in societies. Values embedded in Sungusungu that were linked to the historical identity of Sukuma galvanized people's motivation for participation. The movement had strong rules and guidelines that were to be followed by individuals under threat of punishment. Groups participate within and outside their communities based on their rationalized choices about the benefits of involvement. Sungusungu spread though Tanzania with the conviction that it was capable of maintaining social order by rooting out criminals in society. Adapting Sungusungu ensured safety for all, diminished the fear of witchcraft, and galvanized collective actions within the community to deal with emerging threats.

Social movements influence policy changes, raise awareness about grievances in a society and transform society through changes they advocate. Sungusungu in Tanzania transformed ideas about security and the relationship between local community and security organs. Sungusungu, as a social movement, united people and created the social cohesion necessary to bring security and social order. The movement challenged the government's authority by claiming it had failed in its duty to its people to provide adequate security. Initially, Sungusungu was successful as a movement because it was able to frame problems as societal issues that needed collective action. Sungusungu in Sukumaland emerged not merely as a security agency; instead, it was also a social

movement engaged in the struggle for political identity and autonomy after the government abandoned chiefdoms.

Sungusungu benefitted the government by maintaining public peace in the country and by saving public resources used for law enforcement. The number of criminals arrested, prosecuted and jailed by police declined, thus reducing prison overcrowding. Government enforcement agents rarely dealt with Sungusungu cases associated with witchcraft.

The locally initiated Sungusungu movement fulfilled the goals of peace, stability and security for all as stipulated in the “2025 Vision for the Tanzanian Government” (Thaxton, 2007). In addition, the praise that Tanzania is a harbor of peace is a direct and indirect outcome of these locally established security systems. The self-initiated security efforts have strengthened communities’ stability. Benefits have accrued to individual villages and to the nation as a whole. In addition, Sungusungu provided a venue through which community members felt empowered to work for social change. However, the decline of government support for Sungusungu negatively impacted participation. Fewer people are willing to work for the movement, and those who do are often incompetent. This decline in Sungusungu has created security gaps that have allowed criminals to threaten vulnerable groups, as it will be shown in the next chapter regarding albinocide.

CHAPTER 5: ENVIRONMENTAL JUSTICE AND THE AILMENTS OF A NEOLIBERAL MWANZA

New forms of conflict and competition over resources are emerging in regions throughout the globe, causing populations to adapt and respond to novel economic, security and health challenges. Tanzania's borders Kenya and Uganda is not merely one region where this situation is unfolding, but thanks to the documentary style film *Darwin's Nightmare*, coupled with compelling concerns about the consequences of neoliberal policies and geopolitical realignments within African contexts. The town of Mwanza figures in wider imaginaries of globalization as an iconic site for the victimization of Africans under current economic regimes of resource extraction and export beyond that continent. Mwanza Region borders the southern end of Lake Victoria, forming a commercial corridor between Kenya, Uganda, Rwanda and Burundi, thus giving it political and economic influences in the region beyond its own belonging within the Tanzanian state (Lockhart 2002).²⁰⁵ Mwanza is the second largest urban area in

²⁰⁵ Mwanza region is situated between latitude 1.30° and 3° South of the Equator and between 31.45° and 34.10° East of Greenwich. Lake Victoria separates Mwanza on Tanzanian side from neighboring countries Kenya and Uganda. The region is comprised of eight administrative districts: Geita, Sengerema, Misungwi, Magu, Ukerewe, Nyamagana, Ilemela, and Kwimba. These districts are further divided into approximately 175 wards and 745 villages. The weather in Mwanza is characterized by tropical conditions, with the highest temperatures in March between 28°C and 33°C and the lowest temperatures between April and July, when it ranges between 18°C and 27°C (URT, 2003).

Tanzania, after Dar es Salaam, and is the industrial, commercial and administrative center of northwestern Tanzania (Flynn, 2001). In this chapter, I consider Mwanza Region as an economic frontier and a transport corridor, integrating social, epidemiological, economic, and environmental elements in order to consider the nested vulnerabilities (Adger, Eakin et al. 2009), experienced by Mwanza residents. I offer a chronology of changes in key resource use sectors that comprise a history of environmental injustice during the post-colonial period, alongside consideration of the ways that environmental justice conceptual frameworks can help us understand the challenges facing healers and their clients in contemporary Mwanza.

Since independence in the 1960s, political decisions, climatic conditions and global industrial capital have transformed the ecological landscape in Mwanza, which has the largest cattle population in Tanzania. In addition, Mwanza has been experiencing an in- and out-flow of resources, technology and labor. The situation in Mwanza calls for understanding of nested and interactive vulnerabilities where marginalized groups are threatened by land dispossession, health and environmental risks due to global economies and environmental changes. People in Mwanza are vulnerable due to environmental change; economic market changes; and increased competition with respect to flows of resources, people and information.

These dynamics typify the entire Lake Victoria basin, the largest freshwater body in Africa, and the second largest in the world (second to Lake Superior in North America), where forty-three percent of the surface is covered by water. Historically productive fisheries have in recent decades experienced ecological changes and

degradation as a result of introduced invasive species, rapid industrialization, land use changes, and climate change (Odada, Olago et al. 2006).

Natural capital from the lake has attracted many people who engage in various activities that relate directly or indirectly to the lake, including agriculture, mining, fishing, livestock keeping, and industries. A further element is epidemiological vulnerability. The environmental damage caused by industrial establishments and unregulated informal sectors, the influx of labor, coupled with low healthcare infrastructure has created conditions for HIV/AIDS and other communicable diseases to spread (Barongo, Borgdorff et al. 1992).

In addition, Mwanza's gold reserves have attracted local, regional, and international investors (URT, 2003). Other mineral deposits in the region include diamonds, which is widely operated by artisanal miners. Presently, the region hosts diverse industrial activities including brewers, soft drinks manufacturers, textiles, steel mills, vegetable oil production, soap, and plastics. Mwanza also hosts a busy airport and is a major port city with regular ferries connecting it to Kenya, and Uganda. Further, Mwanza is emerging as a growing tourist destination as is increasingly becoming an alternative to Arusha region, as an entry point for people visiting Serengeti National Park. The plans are underway to build a giant multi-billion commercial complex projects aimed at stimulating businesses and attracting more investors in the region.²⁰⁶ The economic potential in the region, which caters to both regional and international markets, has

²⁰⁶ Source: Mwanza city on a major shopping project, (*Dailynews* Online December 30, 2011) at <http://www.dailynews.co.tz/home/?n=26841&cat=home> accessed February 16, 2012)

attracted foreign investors and aid agencies that complement and compete with one another in resource exploitation, economic development, environmental protection, infrastructure development, and other social programs.

These different activities make Mwanza an area of varied inquiries and interventions—including development programs, environmental management, ecology, cultural studies, and therapeutic processes. Researchers, intrigued by the conditions in Mwanza, are questioning how resource exploitation in the region compromises people's livelihood (Odada, Olago et al. 2006; Spiegel 2009). In contrast to its great natural wealth, many residents of Mwanza live in by poor economic and health conditions. For instance, Mwanzan fish industries exploit aquatic resources for regional and international markets, and declines in fish stocks deprive local populations of sources of dietary protein. More recently, the mining industry has been challenged that its presences instigates tensions, conflicts, pollution, child labor, and prostitution (Emel and Huber 2008; Spiegel 2009).

The social and ecological changes happening in the Lake Victoria basin can be explained using grand ideas, such as sustainability, conservation, and ecological footprint. These concepts strive to ensure human activities do not damage the ecosystems on which they depend. Yet one must cautiously consider conventional wisdom about resources and conflict, and then look beyond unidirectional models of scarcity and competition as drivers of violence, to find specific interacting forces that create increased vulnerability, or elements of adaptive response. In this chapter I use both biological and social concepts of multiple stress effects. This enables me to describe nested, interactive

vulnerabilities happening in Mwanza in the Lake Victoria basin, as those create new concerns and new kinds of clients for traditional healers.

VIOLENCE, VULNERABILITY, AND ENVIRONMENTAL JUSTICE

Completing my education as I have within an historically US focused environmental justice program, I have had to address many questions about the extent to which the core definitions and concepts apply to sites such as those in Tanzania. In the US Environmental Protection Agency's formal definition, indebted to initial conversations and concepts that emerged from an historic conference held at the University of Michigan in the early 1990s, Environmental Justice is:

The fair treatment and meaningful involvement of people of all races, cultures, incomes and educational levels with respect to the development and enforcement of environmental laws, regulations, and policies. **Fair treatment** means that no group of people should bear a disproportionate share of the negative environmental consequences resulting from industrial, governmental and commercial operations or policies. **Meaningful involvement** means that: (1) people have an opportunity to participate in decisions about activities that may affect their environment and/or health; (2) the public's contribution can influence the regulatory agency's decision; (3) their concerns will be considered in the decision making process; and (4) the decision makers seek out and facilitate the involvement of those potentially affected.

This definition echoes Kuehn's (2000) notions of *Distributive Justice*, is characterized by the condition in which all citizens have the same right to equal treatment, such as access to goods and opportunities, as anyone else. Donohoe (2003)

expands Kuehn's notion of relationship between socio-economic conditions and environmental, to define environmental justice as comprised linked of health, environmental, economic, and social concerns. Munnik (2007) expands Kuehn discussion noting that there are mechanisms that produce environmental justice including exclusion, enclosure and externalities. Exclusion involves the system where some groups of people are excluded in decision-making process and their opinions are less likely to be included in activities affecting them. This is no different from Kuehn's aspect of procedural justice which asks to involve groups at risk to participate in the decision making process on issues that impact their lives. Without representation, affected groups have to bear environmental damage costs of the industrial activities and imposed policies.

The enclosure of resources has taken many shapes over time, including colonization, taking over land, water, wildlife, which makes it impossible to escape the dominant systems (Munnik 2007). Consequently, people are then forced to find work in dominant systems and more likely to be paid low wages and subjected into environmental risks. In other words, companies appropriate the benefits before passing on the costs of production to other parties in the form of health conditions and violence.

In Mwanza take different shapes and raise some important questions about the environmental injustice in the region and accountability. "Environmental Justice Disputes," arise at the international, national and local levels (Fritz 1999; Kuehn 2000). Multinational corporations have been accused of search and exploiting natural resources at the expense of the poor in developing nations (Fisher 2007; Spiegel 2009). The unfair distribution of benefits and risks obtained from exploited resources according to Kuehn is environmental injustice. Alienating people from the possibilities, has negative impacts to

the government and the investors revenues. The local media press has captured numerous incidences in which local people have invaded mining investments with intentions of obtaining minerals or sabotaging, leading to loss of lives and properties.

The struggle for people to access minerals in areas land rich of resources is implicated by labeling local people as invaders, illegals, people making encroachment ignoring the fact that they were the were in those areas in the first place. For instance, the online *Dailynews* reports that police in Mwanza Region were launching a special operation to arrest gold miners carrying out artisanal mining illegally in Geita district.²⁰⁷

Land belongs to the government that had decisions to give it to the large investors. Spiegel (2009) notes that “large mining companies own more than 90 percent of mineral rich land in the Geita region, and microcredit is difficult to obtain among poorer groups who do not have land rights and need assistance to transfer to cleaner technology”. In Geita for instance people threatened to invade the Geita Mining Company following the decision by the company to block the road used by people in the area.²⁰⁸ More often local communities are subjected to and burdened by environmental hazards and left out of the decision making process. In the same article people complained that they cannot fish in River Kagusa because of the contamination resulting from waste discharge from the mining company.²⁰⁹ It is an approach that addresses unfairness of development, implementation, and enforcement of environmental laws and policies (Kuehn 2000).

²⁰⁷ Source: Mwanza police mount operation against gold miners (<http://www.dailynews.co.tz/home/?n=12790>) Re-Retrieved on February 24, 2012

²⁰⁸ Source, Mgodu wa GGM Walalamikiwa (*Tanzania Daima*, Friday October 16, 2009)

²⁰⁹ *ibid*

In one sense, then, a key component of environmental justice is access to proper information that enables communities to determine how they respond to environmental problems (McCarthy and Zald 1977; Jenkins 1983; Mohai 1985). Communities in developing countries particularly in areas with rich with natural capital pay a high and disproportionate price for economic development, resource extraction and industrialism perpetuated by multinational companies (Lu 1989). An export oriented economy entailing deregulated trade has an effect on health (Shaffer, Waitzkin et al. 2005). These challenges are leading to increasingly transnational theories and practices of environmental justice research. Core meanings for most scholars and practitioners still refer to those cultural norms and values, rules, regulations, behaviors, and policies that determine whether people will have confidence that their environment is safe, nurturing and productive. Research conducted in the U.S. has offered correlations that pertain in a site such as Mwanza, for instance that living in proximity to a pollution-producing facility is related to individual and family distress (Unger, Wandersman et al. 1992).



Figure 15: A caption reads 200 people invade North Mara Gold Mining in Mara.

For instance, the *Nipashe* daily newspaper reported that more than 200 people invaded the North Mara Gold Mining in the Lake Victoria Basin, using machetes, spears and arrows for what was said to collect gold ores (Figure 15). The Police District

Commander was quoted saying that was the third consecutive invasion in two weeks.²¹⁰ The company has become a focal point of conflict as another report indicated that five people were killed when local people (estimated between 800 – 1200) armed with traditional weapons invaded the mine, from what was reported as stealing gold ore, and police responded to the attack using live ammunition following the resistance of the people to vacate the compound.²¹¹ The report further indicates that in 2008, about 200 people attacked the mining destroying property worth \$ 7 million, and suspending the operations.

Likewise, globalization policies are now jeopardizing health by eroding social and environmental conditions, exacerbating the rich-poor gap, and disseminating consumerism. Global environment changes pushes for urbanization and increased informal sector that involves selling of different products without proper regulation, consequently leading to land degradation, depletion of terrestrial aquifers and ocean fisheries, and loss of biodiversity. This weakening of life-supporting systems poses health risks (McMichael and Beaglehole 2000). In Mwanza for instance, while the palatable fish fillets are exported to the European markets, local populations have to compete for fish bones and heads that are more likely to be contaminated with unknown pollutants (as

²¹⁰ Similar incidences have been reported by the international media sources. *Reuters* reports *Barrick suspends Tanzania mine output after class*. News accessed on December 30 from <http://www.reuters.com/article/2008/12/12/barrick-mine-idUSN1247233520081212>.

²¹¹Source Five killed in Barrick Tanzanian mine attack –police from <http://www.reuters.com/article/2011/05/17/tanzania-barrick-attack-idUSLDE74G09W20110517> accessed December 30, 2011

explained in previous section). In other words, these corporations reap the benefits while creating environmental problems and other social disruptions.

Such concerns ought to align with increasingly fine-grained, high-profile studies that include sites in Tanzania, and consider how communities are able to manage resources and monitor individual use to ensure continued multiple economic and ecological outcomes from a given resource base (Persha, Agrawal et al. 2011). Still challenging, however, is the conceptual frame for how resource use issues in developed sites constrain or enable such successful protection, management, and public engagement in less developed areas that are providing resources and all too often receiving waste from the former

As in other parts of Africa, the presence of natural resources in Mwanza continues to attract new foreign direct investment in what Munnik (2007) calls “a new scramble for Africa resources.” The exploration and exploitation of resources in the region that, to a large extent, involves marginalization of the local people and creates different forms of crimes, injustice, occupational health, and resources violence (Fisher 2007; Spiegel 2009). Such conflicts have been reported in many countries, however, the discussion of resource violence and environmental injustice in Africa tends to politicize visible violence, such as wars over resources in Congo, Sierra Leone, and Nigeria (le Billon 2001; Ross 2004). Invisible violence, however, produces similar suffering to that of physical violence, although the damage is slower and more subtle (Winter and Leighton 2001). Both, visible and invisible types of violence limit hopes of economic prosperity and social development in in many African countries (Krug, Mercy et al. 2002). Poor health, environmental risks, and labor migration due to unequal or limited access to

resources and/or environmental pollution represent forms of environmental injustices (Mohai and Bryant 1992).

Based on local conditions in Mwanza, Tanzania like for other developing countries and continued external pressures for labor, resources and market from developed countries Bunyan at the University of Michigan suggests for more inclusive definition of environmental justice.²¹² Environmental justice paradigm needs to cater for conditions in both developed and developing countries because the contemporary social and economic institutions are based upon ecological systems. It is fitting that such a definition would be inclusive. The proposed definition differs from the environment justice definitions used in the United States, which are narrower in focus. While such definitions are usually focused on a narrow range of policymaking, they fail to address the underlying and structural conditions responsible for such injustice. The definition by Professor Bunyan Bryant (1995) although more conclusive,²¹³ it fails to address the needs of people in developing countries. The new definition of environmental justice differs from any definition to date; it differs because in countries where multinational corporations are powerful, and where governments are weak or controlled by them, and

²¹² Discussion between M. Jangu and Professor Bryant Bunyan, University of Michigan. February 25, 2012.

²¹³ Environmental Justice (EJ) refers to those cultural norms and values, rules, regulations, behaviours, policies, the decisions to support sustainable communities, where people can interact with confidence that their environment is safe nurturing, and productive. EJ is served when people can realize their highest potential, without experiencing the “ism.” EJ is supported by decent paying and safe jobs; quality schools and recreations; decent housing and adequate health care; democratic decision-making and personal empowerment; and communities free of violence, drugs, and poverty. These are communities where both cultural and biological diversity are respected and highly revered and where distributed justice prevails (Bryant, 1995p.6)

where civil society is weak, such a definition must draw upon the force of the Universal Declaration on Human Rights and the United Nations Convention on Genocide.²¹⁴

Environmental justice is the enhancement of the earth's ability to provide the conditions for life evolution by maintaining healthy relations to an abundant and variety of plants and animal species, rich and fertile soil and clean water and air. Environmental justice is the internalization of the full environmental and social cost of commodities and services to provide sustainable environments and healthy livelihoods, physical and mental well-being, human rights and human dignity, transparency and accountability of governance to civil society or citizens regardless of income or wealth, tribe, gender and age. Environmental justice is the right for people to both own and cultivate land sustainably for and housing and food security. Environmental justice supports culturally embedded or medical practices that use ecological remedies without harm.

Environmental justice is the right to be free of structural inequalities; more specifically, it is the right to be free of ecological destruction and violence against women and children, and the wanton destruction of plant and animal species during peacetime and war. Environmental justice is the respect for the biophysical and social environments. It is respect for all life. For example, genocide, sex trafficking of young girls and the militarization of children whose lives are torn apart by wars is morally wrong and are gross violations of the Universal Declaration on Human Rights, and the United Nations

²¹⁴ Discussion between M. Jangu and Professor Bryant Bunyan, University of Michigan. February 25, 2012.

Convention on Genocide. The new proposed definition is aimed to be holistic and cater for multitude of factors that restricts people from benefitting from ecological services.

Studies show how altered ecological services are influencing mobility of the population featuring conditions such as in and out-migration (Meertens, Fresco et al. 1996; Sunderlin, Angelsen et al. 2005; Vanderpost 2006). Baechler (1998) notes that resource exploitation and overuse tends to lead to ethno-politically motivated conflicts. Canter and Ndegwa (2002) have a different opinion, suggesting that competition over declining resources does not always tend to influence violence, wars and conflict. While the magnitude of conflict might not be visible, there are subtle forms of violence that have been studied and linked to the ecological services in the basin. For instance, child labor and street children are common problems (Fisher 2007), and high prevalence rate of HIV/AIDS are high in is also linked to fishing and mining activities in the basin (Rugalema 2000; Lockhart 2002; Clift, Anemona et al. 2003; Desmond, Allen et al. 2005; Lockhart 2008). Pollution and water borne diseases are as well common and are linked to contamination of sources in the region (Kinabo and Lyatuu 2009). And recently, the violence against people with albinism has been directly linked to fishing and mining industry in the region (Bryceson, Jønsson et al. 2010).

Urbanization, widely characterized by construction, intensive land use, migration, and increased resources consumption, is a common feature that threatens the public health in Mwanza. Continued stresses in the basin, such as migration, mining, over fishing and land use changes in the lake basin, threaten living conditions of more than 30 million people in the catchments from Kenya, Uganda and Tanzania. In addition, the lake is said to generate different products that would make a combined annual income of

approximately US\$ 3-4 billion (Odada, Olago et al. 2006). One uncertainty is the extent to which socioeconomic and environmental changes affect health conditions and African traditional healing practices, as both traditional healers and biomedical practitioners contextualize the role of political processes and environmental landscape of illnesses and therapies.

The increased population in the region contributes to multiple environmental challenges such as massive exploitation of resources and increased generation of waste is more than the capacity of the existing sewage infrastructure can handle. The 2002 Population and Housing Census shows that the region's population had reached 2,942,148 (1,459,570 males; 1,482,578 females), with the population growth rate at 3.2 percent.²¹⁵ However there is variation between stated growth rate provided by the government (2-3% each year) and the observed growth rate particularly in Mwanza city according to the Municipal Director, perhaps because of shifting municipal versus regional lenses being used. In a discussion with the Director in June 2007, he suggested that the actual annual growth rate for the Mwanza city is 11 percent.²¹⁶ Mwanza city is estimated to have a population of over one million people,²¹⁷ and is now considered densely populated by global standards, with an estimated 1,200 people per square kilometer (von Kaufmann, 2007). This far exceeds the world average of 43 people per square kilometer, and is even above the Tanzanian average of 41 people per square

²¹⁵ More details at <http://www.tanzania.go.tz/census/census/maps.htm>, last accessed April 5, 2012

²¹⁶ Discussion between M. Jangu, T. Lawrence and the Mwanza City Director: Mwanza June 11, 2007.

²¹⁷ Source: Mwanza city on a major shopping project, *Dailynews* Online (December 30, 2011) at <http://www.dailynews.co.tz/home/?n=26841&cat=home>

kilometer. Rapid population growth through immigration and improved health conditions had impacts on land use and land cover in the region due to the intensification of large-scale deforestation and agricultural conversion (Verschuren, Johnson et al. 2002).

Many residents of Mwanza live in congested areas lacking adequate sanitation services. Others occupy space in hills and valleys where sanitation systems are not installed. Unplanned settlement in the region has also led to the massive discharge of untreated wastes from both industries and municipals to Lake Victoria, the major recipient of all forms of waste in the regions. The haphazard discharge of municipal and industrial waste along with uncontrolled vehicular emission pose health hazards to the people in the region. The impacts of environmental pollution are evidenced by the magnitude of waterborne diseases in the region (Mwanga, Magnussen et al. 2004). For instance, in Mwanza city the municipal sewer systems only cater to seven percent of a population (Mwanuzi 2006). Data from the Sekou Toure Regional Hospital indicates a high prevalence of waterborne disease due to the unsanitary conditions in Mwanza (Machiwa, 2002). Interdisciplinary studies also indicate the decline of water quality and increased cases of water borne diseases in Mwanza.²¹⁸

Malaria is also common in the region and is attributed to the poor sanitary systems and increased population growth (Feenstra, 1998). Regional data shows 95% of all illnesses in Mwanza are caused by ten diseases: malaria, acute respiratory infections (A.R.I) diarrhea, pneumonia, intestinal worms, eye infections, skin infections, minor

²¹⁸ A study, "Socioeconomic determinant of health in Mwanza Tanzania," conducted by a team of faculty and students from the University of Michigan in 2007 in Mwanza established the way in which the quality of water resources has declined thus leading to the increased cases of water borne diseases in the region. Stein et al., (2007). Socioeconomic determinant of health in Mwanza Tanzania. University of Michigan. Unpublished raw data.

surgical conditions, urinary tract infections (UTIs), and anemia. Of those ten, malaria is the leading cause of morbidity and mortality in the region, though debates exist about whether HIV/AIDS is closing in on Malaria as the major killer. The magnitude of health problems is further amplified by poor economic conditions, as people cannot afford their medical expenses (URT, 2003). The most affected groups here are the poor who are more likely to live in unsanitary conditions with limited financial resources to attend their health problems.

Likewise, the presence of mineral resources in the region has created tensions and competitions between different actors. Both local and international press have reported numerous incidences where people in the neighborhoods of Mwanza have invaded industrial complexes sabotaging, fighting with guards for encroachment to access minerals, and in some occasion police forces have intervened and been accused of killing people (Kitula 2006; Fisher 2007; Fisher, Mwaipopo et al. 2009).

The more important point for the purposes of this chapter is that increasingly differential access to resources in the region feeds ever-increasing vulnerabilities (Adger, Eakin et al. 2009; Eakin, Winkels et al. 2009) and competition between agencies, to the extent that people's abilities to eat, secure jobs, and protect themselves from communicable diseases have been compromised. The situation in Mwanza indicates forms of environmental injustice that illustrate linked economic, ecological, and epidemiological effects. Those who lack the means to adjust to a competitive environment are most at risk. However, rather than dwelling on competition and conflict as it relates to anarchic or unstable forms, I trace the persistence of healing as a set of constructive, inventive responses to these challenges. In so doing, I seek to contribute to a

small new stream of African intellectual work that moves beyond and critiques grand narratives of victimization and violence to ask what forms of trade, governance, and service provision can emerge from and works within fragile African regions where national sovereignty is not monolithic (Kabamba 2008).

BIOSOCIAL “MULTIPLE STRESS” EFFECT

Mwanza is at the center of political transition (development programs), expansion of extractive industries, environmental changes and different forms of environmental governance. Past agricultural activities and animal husbandry had some adverse environmental impacts, such as land degradation through soil erosion, pesticide contamination, and nutrient loading in water bodies. The introduction in the 1970s and 1980s of modern farming that advocated for high yield through use of hybrid seeds, fertilizers, and pesticides had short-term positive impacts. As the years have progressed the land has become less tenable for agricultural activities and agricultural practices could hardly be controlled by people as they had to purchase seeds and fertilizers. The varied climatic and weather conditions further complicated agricultural activities mainly due to the long duration of drought and unreliable rain (Flynn 2001; Hongo and Masikini 2003).

Maintaining different economic activities in Mwanza depends on a sustainable and stable ecosystem that continuously supplies ecological services. The interaction between humans and the environment is not sustainable, thus impacting the region's ecology and epidemiology. Studies have indicated that the rate of environmental degradation in the basin threatens the survival of ecosystem services provided by the lake to both local and international populations (Verschuren, Johnson et al. 2002).

Proliferation and intensification of land uses, increasing population, effects of climate change, and introduction of invasive species have all altered the natural ecosystems and social structure in the Lake Victoria basin.

While similar regions/areas have been studied using concepts of multiple stressor effect (Sundbäck, Alsterberg et al. 2010), current literature on the basin is fragmented and not holistic in its approach. Yet such conceptual models are urgently needed, and multiple stressor analysis is not only a theoretical approach that explicitly explains the stability of the ecological systems, but also a research process that enables one to prioritize intervention measures in addressing environmental and social problems. In sum, the multiple stress paradigm is appropriate due to the combined effects of different forces that are now shaping ecological and social conditions in the basin.²¹⁹

The concept of multiple stresses cannot be discussed in isolation of concepts such as vulnerability, adaptability and mitigation measures. *Stress* as a concept is considered an important aspect in describing the process of transition towards sustainability (NRC, 1999 p.224). As a slightly fuzzy boundary concept, it fits less easily within an environmental justice tradition that valorizes specific data on toxin exposures, for instance, Yet Advocates for sustainability are having concrete conversations about stabilizing population growth rates, improving the quality of ecological supporting systems, and innovating technologies that are not damaging. These efforts are aimed at ensuring hunger and poverty eradication and also addressing inequality. As such they

²¹⁹ Bails et al. (2004). Prescription for Great Lakes Ecosystem Protection and Restoration: Avoiding the Tipping Point of Irreversible Changes. Accessed on December 29, 2011 from <http://healthylakes.org/wp-content/uploads/2011/01/Prescription-for-Great-Lakes-RestorationFINAL.pdf>

contribute to increasingly transnational concerns with in environmental justice scholarship.

Studies related to environmental change and accuracy in predicting the impacts and incorporate mitigation measures require a framework that examines and integrate the impacts associated with *multiple stresses*. *Multiple stresses* as a concept in climate change appears to have evolved in different contexts. However, in late 1990s, the concept took a different shape where the “multiple stresses” discourse was used to describe economic and social conditions. In ecological systems and terms, a *stress* is defined as an interruption or disturbance to people’s livelihood that are forced to adapt to the changes happening in the physical environment (Adger, 1999). Vinebrooke et al (2004) define a stressor as an abiotic or biotic variable that exceeds its range of normal variation, and adversely affects individual physiology or population performance in a statistically significant way.

However, the abiotic and biotic stressors usually do not operate independently, but rather often interact to produce combined impacts on ecosystems. In the 1995 IPCC, A Report of the Intergovernmental Panel on Climate Change, the term “*stress*” is used along with the systems’ sensitivity and adaptability to climate change, “Human-induced climate change represents an important additional *stress*, particularly to the many ecological and socioeconomic systems already affected by pollution, increasing resource demands, and non-sustainable management practices” (p.6).

Schroter et al (2004) also argue that multiple global change drivers such as socio-economic change, land use change, and climate change are the likely *stressors* that impact the natural ecosystems. A similar observation is acknowledged by the National

Research Council when discussing problems associated with “stresses” in their document, *Our Common Journey* (NRC, 1999, p. 278)

Most problematic threats to people and their life support systems arise from multiple, cumulative, and interactive **stresses** resulting from a variety of human activities. Unfortunately, our collective ability to create reliable scientific knowledge about such integrated problems remains limited due to the inadequacies of observational data, the immaturity of relevant theory, and the underdevelopment of an appropriate professional community to provide meaningful criticism.

Adaptation is the condition in which system responds in order to reduce vulnerability, or an ability of a system to cope with or absorb *stress*, whereas vulnerability is the degree to which an individual, system, or subsystem is potentially susceptible to harm or damage due to exposure to stressors (Adger, 1999; Turner et al, 2003). Vulnerability concept has also been associated with historical events that subject people to a range of *stresses* such as climate change, political and economic conditions. The concern of multiple stressors is the possibility of synergistic interactions, thus causing compounded ecological and social threat to the integrity and function of ecological and social systems (Adger et al. 2009).

JUSTICE ISSUES FOR HEALERS AND OTHERS IN MWANZA FISHERIES

Fisheries in and around Mwanza have been both a subsistence mainstay for wide swathes of the population, and an economic engine for various elites. This section considers both the factors contributing to that fishery’s recent decline, as well as the kinds of processing practices that have become a parallel economy that meets many local nutritional and economic needs, while creating specific forms of pollution. Finally, I will consider the outcomes for healers who historically used fish and marine mammals such as otters in healing rituals and who have seen their access to this resource constrained.

Through this fisheries case study, I will illustrate the nested vulnerabilities of varied human and animal actors in the Mwanza landscape.

Politically, Lake Victoria is highly complex and difficult to govern, both despite and due to its role as a cosmopolitan economic and geopolitical frontier. Notes one journalist:²²⁰

The Lake is also used by pirates, smugglers and unscrupulous criminal elements...In these days of climate change and growing populations, the lake is undergoing so many pressures which can be mitigated by countries making sacrificial commitments. We call upon the executives and legislators not to debate but pass commitment towards conserving and sustaining this water body.

Fisheries expert Lusekelo Mwambuli suggests that Lake Victoria as a whole was capable of generating 500,000 tons including species such as Nile Perch, *dagaa* and *magege*. In addition the fish industry in the Lake Victoria region provides about 197,000 jobs for fishermen with about 600,000 opportunities for businessmen and women.²²¹ Mwanza is the biggest exporter of filleted fish in Africa. Two years ago the City of Mwanza was capable of collecting revenues reaching Tsh. 400 million from fish industry mainly from fish landing sites as well as fish industry. Today revenues have dropped by almost half (approximately Tsh. 200 million) due to the declining productivity of the fishery. Responding to the situation as quoted by *Raia Mwema*, the City Mayor Willson Kabwe attributed the decline of marine resources to the *uvuvi holela* (illegal fishing).

Ecologically, Lake Victoria experiences various kinds of stressors including climate change, extreme events, pollution, invasive species, and land and resource use.

²²⁰ Source: E.Africa: Support Lake Victoria initiative (*ThisDay* August 9 -15, 2010), Also available at <http://allafrica.com/stories/201008040160.html> accessed on March 13, 2012

²²¹ *Raia Mwema* (May 12- 18, 2010): *Mwanza Jiji Linalokuwa kwa Kasi Afrika Mashariki*. (Mwanza among cities growing fast in East Africa).

The decline of water levels in Lake Victoria is a result of varied climatic conditions. According to Chacha (2006) the Lake Victoria level has been 19 cm above the lowest level noted in 1896. Tanzania is said to be losing 2 percent of its Gross Domestic Product (GDP) equivalent to TSH. 600 billion due to climate change.²²² Changes in temperature and decreases in oxygen levels have created ecological imbalances that threaten the life sustaining system of the Lake Victoria basin. Vinebrooke et al. (2004) note the need of having a better way of understanding the interactive effects of multiple stressors which are multiplying over the years.

In addition, the lake is threatened by both industrial and municipal pollution.²²³ People in Mwanza now experience a clash of between economic development, environmental protection, and sustainable development. These intertwined issues have transformed themselves in a national and global political agenda. In 1997, for instance, the European Union (the major consumer of Nile Perch from Lake Victoria) visited industries in the region and government environmental and fisheries institutions and recommended that industries must adhere to set quality and industrial standards for the

²²² Alphonse Bukulamchi presented a paper on “carbon trade” at the two-day forum on climate change forum organized by the Vice President’s Office noted the impacts of climate change are seen on the disappearance of snow on Mount Kilimanjaro, the decline of water levels of water bodies such as Lake Victoria that have social, ecological and economic impacts (Source: “Tanzania loses 2 percent of GDP to climate change” reaccessed on April 10, 2012 <http://www.ippmedia.com/>)

²²³ In recognition of the impacts to the Lake, the Lake Victoria Basin Commission was planning to launch a new bid to finance its environmental management and conservation activities. The commission needs \$25 million every year to run its activities. In fact all the East African Community (EAC) member states, NGOs and the private sector will fund the initiative aimed at consolidating efforts to ensure sustainable management of the natural resources which directly supports 50 million people and indirectly 120 million (Source *ThisDay Auguts 9 -15, 2010 E.Africa: Support Lake Victoria initiative*)

European market if they want to continue exporting fish. These visits helped to improve industrial operations; however, other conditions remained unchecked. The management of waste from these industries and the impacts of fish industries in the region was not a priority for the European Union representatives. Their visit seems not to have covered the entire process chain of both the products and by-products. If this could have been observed the situation reported in various media sources and the release of the controversial documentary *Darwin's Nightmare* could have been different.

Ecosystems degrade and the ecological basis of human life is undermined with increasing throughput in the human at the expense of other systems (Schnaiberg *et al* 2002). Despite economic gain for the nation from the Nile Perch fillet industry, the local population bears disproportion health and environmental risks caused by industries. Lack of income and access to marine resources has now pushed people to adapt to new ways in which they can



Figure 16: Processed Nile Perch heads and bones in Mwanza.

maintain their livelihood (Pringle 2005) process and consume fish heads and bones for their livelihoods, the waste from Nile perch industries (Figure 16). The processing of fish heads has grown in areas that were designated dumping places creating new social, economic systems for people livelihoods. More often expansion of industries are associated to in migration of the labor for the products, but Nile perch presence in Lake Victoria has created new forms of livelihoods from what was considered wastes that characterized Mwanza through images portrayed by the *Darwin Nightmare's*

documentary. In my observation and interviews I show how people in the areas have benefitted from *panki*.

Contrary to negative publicity of the fillet industry painted by the Darwin Nightmare documentary, a new industry emerged where people started processing fish heads and bones that were initially considered of no value, contaminated with other wastes, and had to be disposed. However, the fish bones and heads started gaining value locally and internationally, conditions that increased their demand. I bring the story below from my observation and interviews I conducted with people operating at the site where fish heads and bones are processed Juma Charles.²²⁴

Located at the outskirts of the city about 12 km from Mwanza town, Nyamhongoro village became a place where fish bones and fish heads, initially considered wastes, were processed. The place was initially unoccupied and was free land used as a grazing field. The site deemed appropriate for the disposal of the fish bones and heads. However, the booming of Nile Perch business transformed changed the area to become residential and business site accommodating people from other Eastern and Central African countries such as Kenya, Uganda, and the Democratic Republic of Congo. The transformation was mainly a result of expanding business of fish heads and bones, fat, and *mabondo* (maws/gas bladders).

Nyamhongoro was the one of the three sites initially designated as dumping sites for fillet industries operating in Mwanza. The choice was based on the idea that it was isolated, far from residential places to avoid the foul smell of decomposing fish remains.

²²⁴ Interview, Jumanne Charles, Nyamhongoro-Mwanza, June 16, 2007; May 14, 2009

The selection of the site was a blessing for petty businesspeople directly and indirectly involved in fish heads and fish bones business. People converted the valueless product into a valuable product that could be exported to the neighboring countries. The fish product became popular people named it as *panki* (literally compared to punky hair cut style at that time in the 1980s). The way fillet were removed was linked to the hair cut. These *panki* are obtained after industrial processes in which fillet are extracted and shipped to the international markets, such as Europe, Israel, US to mention a few. The *panki* in Nyamhongoro are the byproducts of fish industries operating in Mwanza including Nile Perch; Tan Perch; Omega. Other places designated for disposing these byproducts were Kishiri; and Mkolani, with Nyamhongoro the largest of all sites in Mwanza.

Initially fish heads and bones were haphazardly disposed by industries; they were mixed with other industrial wastes; thrown on the ground and contaminated with soil. There was no consideration that people would consume what was considered valueless waste. Then People started processing *panki*, drying and milling them as chicken feed. Slowly people started consuming the dried fish bones and fish heads that were intended for chicken meal. The business of *panki* started to flourish in the early 1990s, and in 2001 the business of *panki* reached its peak due to the high demand at the international market, increased industrial output and intensification of exploitive potential of Nile Perch in Lake Victoria. The respondent, Juma noted that that was time when many people made huge profits from *panki*, mainly because they were accessed from industries and the labor cost were relatively low. Industrialists realized that people were making profit out of the fish heads and bones as many people competed in industries to gain access. Many people

contacted industries to buy *panki* and process them before selling them. Instead of industries incurring expenses to transport waste, they started benefitting from what was initially considered as waste. Industries benefitted in two ways by reducing the transportation and disposal costs, and also by selling them.

In my visits at the site in 2007 and 2008 respondents noted that industries had different prices for the fish bones and heads. For instance, the Omega industry sold each ton between TSH. 30,000 and 35,000 thus for each truck weighing 10 tones were sold at TSH. 300,000 – 350,000. The respondent noted that for the transportation cost from the factory was between Tsh 40,000 – 45,000 for each trip and also paying loaders TSH. 2000 for each tone. Other industries had different procedure of selling the fish bones and fish heads. Industry such as Nile Perch and Tan Perch did not sell using the measurement of tonages instead their selling were based on the amount loaded in the truck and the cost was about TSH. 300,000 – 350,000. However, these industries offered free transportation for the customers.

The business reached its peak in the late 2000s as more than 15 trucks arrived in the area. The trucks offloaded the *panki*) before undergoing procedures that included; 1) sorting and separating fats that were cooked and used to frying *panki* and other food for human consumption. The oil was also used as frying oil for the fish that come direct from the lake. 2) Intestines were also sorted out, dried, mixed with other ingredients to make chicken meal. Each kg was sold at TSH. 100/=. Others preferred mixing these intestines with bones and selling a kg at TSH. 160/=. People preferred mixing the two to maximize profits. 3) The third process involved separating bones and heads that did not have any substantial fillet, then sun dried the products before milling to make chicken meal.

Likewise, each kilogram fetched TSH.160.00. 4)The last procedure involved separating *panki* with fillet and this is a product that is consumed by humans after it has been fried or smoked using grains husks (rice husks). However, other consumers preferred buying it while fresh.

The business *panki* catered for local and external markets. In most cases according to Jumanne the internal markets for both chicken and human feed were Bukoba (large market), Bariadi, Shinyanga, Bushirombo, and Geita among others. The external market involved countries such as Uganda and DRC (the large share), with little amount sold in Kenya. In Uganda according to Juma, the fish heads for human consumption were sold at US \$ 1.00 for each kilogram that was equivalent to TSH 750 at that time. Therefore, business people shipping 100 kgs were entitled to get US \$100.00, which was equivalent to TSH. 75,000. People transported shipped processed products by ships to Bukoba, and on their arrival in Bukoba hired trucks that transported the products to the boarder with Uganda and Zaire for external customers.

The presence of this industry in Nyamhongoro attracted different groups of actors doing different kinds of business. Some fetched and sold water for domestic consumption and for cleaning fish remains. Two methods were used to supply water at the site including boreholes with each bucket of water sold at at TSH. 200.00. Secondly, other people brought water on bicycles carrying three jerry cans at TSH. 200.00 each can during rainy season. During dry season prices for water increased and water obtained from bore holes was sold at TSH. 500.00 People bringing water by bicycles sold each bucket at TSH. 200.00 per each jerry can. When asked if the water in the area is safe and

clean the respondent noted that the water is safe as for eight years 1998 – 2006, there was no single event of eruption of waterborne disease.

The site's particular environmental problems were popularized by the *Darwin's Nightmare* documentary which featured spectacular footage of the foul smelling mounds of decomposing fish product. However, since the film's release, *panki* are now received and properly processed and stored. Incoming trucks dump the fish products in *makaro* (concrete floor) aimed at avoiding contamination with sand. The products that are aimed to feed chicken are dried on the ground during dry season, and kept on frames during rain season. For human consumption there are *matenga* (wooden baskets) that are well packaged and covered with plastic materials. Products for human consumption are smoked in *matanuru* (drying furnaces), others are put on frames to dry by sun and others would be fried and packed in plastic packages. Generally, then, the processing environments have improved, but the major problems are *funza* (maggots) and smell which are hard to control. Maggots have infested the area. The area also hosts different kinds of scavengers including birds and some mammals such as dogs and cats, thereby constituting a complex food chain.

Initially the business could be run with little money because fresh fish heads and bones from the factory were accessed freely. In 2007 according to the interviewed people the capital required amounted between TSH. 500,000.00 to 1,000,000.00. The business is operated in many various ways, for instance, a customer buying chicken meal might pay in advance for the processed meal. The customer will agree with the producers about the amount of chicken meal to be purchased and then it will be the responsibility of the processors to collect raw materials and process them as agreed. One of the examples

captured is that a customer may offer TSH. 1,000,000 as an advance payment for the processed product. If the person fails to meet the expectation is liable for his properties to be confiscated. For instance, an individual was given TSH. 6,000,000 and failed *kukusanya mzigo* (solicit the product), consequently his *shamba la miti* (tree farm) was confiscated.

Many different people have visited this area from environmental institutions and other individuals with their own interests. Respondents noted that the place has been visited by people who portrayed bad image of the area. They noted that at one point Japanese people made a visit and took pictures of people and the environment and later they produced a film which denigrated people in this area that they were eating dirty stuff (*makombo ya uchafu*). Such kinds of events have angered people in the area and taking pictures requires trust. In summary, the business of *panki* has enabled people sustain their livelihood as many people in the area do different kind of businesses such as retail shops (*vibanda and maduka*) selling different products. In addition, women have been able to open *magenge* where they cook and sell food for people in this area and those who are working in this site. The area has become very active. However, activities in the area are declining due to the decline of the Nile perch in Lake Victoria the condition that has affected the fish industry in Mwanza.

The above is adaptive strategy in which people have responded to ecological changes happening in Lake Victoria. However, many other people remain vulnerable to the changes. The decline of Nile Perch has spillover effect on socioeconomic activities in the region. Majority of the women previously engaged in the traditional processing and trading of the marine resources have lost their businesses. The export oriented economy

for Lake Victoria resources has reduced income and fish consumed locally leading to multiple effects both on poverty and health due to malnutrition (George 1988; Geheb, Kalloch et al. 2008). Conditions in Mwanza can be explained using Kuehn's (2000) social justice's framework to describe environmental inequity. He notes that lower income groups have not been fairly treated on issues related to the benefits and burdens of resources availability, acquisition, and distribution.

EXTERNALITIES VIA ECOLOGICAL MANIPULATIONS

Mwanza is a region linked to both the political decision making processes and ecological manipulation for profit gains that have ignored externalities. The large-scale ecological manipulations impact lentic ecosystems and communities, stemming from open access and massive exploitation of fishes. Costs that are not incorporated in the market process (externalities) render economic and ecological sustainability impossible. These externalities create significant social impacts that are hard to quantify. Resource extraction has been associated with health problems, civil wars, human rights abuses, corruption, poor governance, and environmental damage (Humphrey, Lewis et al. 2003; Bennett and Balvanera 2007). These problems are the result of negotiations between investors and government officials, which prioritize technical and commercial aspects of resource exploitation while ignoring the environmental, social, economic and political implications of the investments (Radon, 2007 p.91). Ayres and Kneese (1969) note that externalities, such as impacts associated with the disposal of residuals resulting from consumption and production processes are inevitable parts of industrial operations. Their economic significance tends to increase as economic development proceeds, and natural

resource services become increasingly important. The unequal distribution of resources in the region has resulted, among others, in crimes, poverty, and violence against people with albinism.

Mining and fisheries have absorbed capital investment and large quantities of labor from rural areas, concentrating great numbers of male workers (Hunt 1989). The interaction between humans and the environment in securing resources takes many shapes and is determined by various factors, such as type of resource (renewable or non-renewable), the existing governing institutions, level of technology; the presence of international investors. For instance, Moore and Vaughan (1994) have examined changes in citemene production over time, including the shift to alternative agricultural production models (cash-cropping) that affects nutrition at the household level in the Bemba community in Zambia. In their analysis and adhering to their model of examining the way that rural Bemba practice farming, they escape the trappings of a discourse that lays the blame of malnutrition squarely on the practice of cash-cropping. Moore and Vaughan suggest that malnutrition is not necessarily caused by abandoning subsistence foods for cash crops, rather may not occur or can occur for reasons such as a change of their staple diet or decreased participation in collaborative networks.

Coronil (1997) describes the transition of a state (in this case Venezuela), where natural capital (oil) influences both internal and external factors in defining “the state of a state,” paying particular attention to aspects such as political events, trade, international relations, culture and development. Natural capital, such as oil facilitates the intersection of world trade agencies, and free market capitalism. Oil production is seen as a driving force to reconfigure the state, establish social relations and create a trajectory of a state

with its relation with other countries. Corinil's work reveals the intersection of space and nature while recognizing contradicting aspects between trade, power relations, and people's livelihoods. Oil resources have positioned Venezuela in the international cycles of trade, and the creation of internal modernity within (p.390). The natural capital oil and its effect on political and economic conditions can be extrapolated to explain how resources such as gold and fish in Mwanza, continue to reconfigure the Tanzanian state in the international market. The presence of precious minerals and fishing activities in Mwanza explain the intersecting and interacting aspects of different economic activities that shape political, ecological, and socioeconomic conditions in Mwanza.

MINING AND ITS IMPLICATIONS

Historically, the mineral-led industrial revolution significantly transformed the political economy of Mwanza, with the creation of a colonial political hegemony over the regional African kingdoms and the intensification of imperial involvement in the sub-continent (Dubow 2004). The expansion of extractive industries in the region is widely dominated by external investors, and facilitated to a great extent by globalization processes. The new forms of resources appropriation is not different from the way in which resources were appropriated during the colonial era, where colonials appropriated the landscape and alienated Africans from it (Maddox 2003). In many regions, with an abundance of resources, local communities have become alienated and asked to vacate, and coercive measures supported by legal instruments have been used to relocate resisting locals. More often, local people have resisted, thus creating tension and conflicts between them, the government, and investors.

The abundance of mineral resources in Tanzania is considered to be an opportunity that will raise the national economy through foreign exchange. For instance Tanzania is ranked third in the export of gold after Ghana and South Africa, with a large proportion of more than 90 percent of the export coming from the Lake Victoria Gold Fields (LVGF). In the past two decades, Tanzania has greatly invested in mining, with most of the operating companies owned by external investors. Small-scale miners are forced to relocate to areas where they add more pressure to the environment as a result of their competition for access to resources using weak technologies.

The daily newspaper, *The Guardian* reported that more than 6,000 artisanal miners pose health risks for the community of 80,000 living in the catchments of Lake Victoria, because of their use of mercury in gold processing, which

is released into water sources (Wang’anyi, 2006). More often the artisanal miners have not received support in innovative technologies, as the government has paid more attention to the investors with large capital. The artisanal mining of diamonds in Mwanangwa and that of gold in Ishokela both in Misungwi district have recorded numerous social and environmental problems (Figure 17). Health risks such as waterborne diseases due to poor sanitation are also common in these sites.

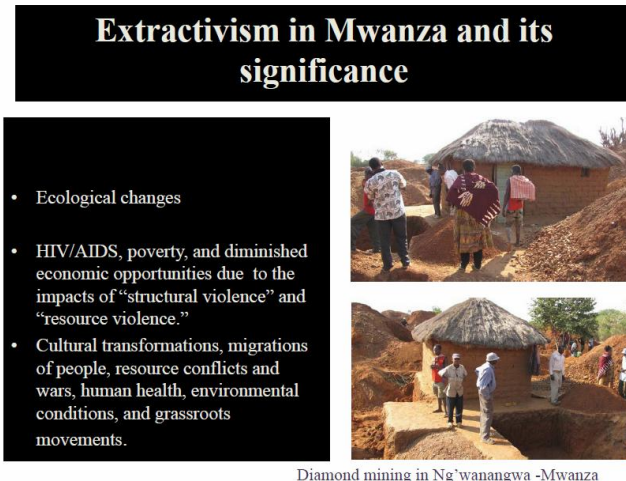


Figure 17: Artisanal diamond mining in Ng’wanangwa-Misungwi.

Records indicate that mineral production in Tanzania increased by 51 percent from 1990 to 1991 and again by 24 percent the following year after implementation of a trade liberalization policy in 1985 and the National Investments Act in 1990. Madulu (1998) notes that the government has continued offering various large-scale private miners mining rights on hundreds of acres of farm land. Mining companies are accused of expanding areas illegally, displacing native people. The expansion of the Geita Gold Mine, for instance, has displaced about 1800 people in three villages in Mwanza (Kitula 2006). This move left many peasants with an uncertain future due to loss of arable land and removal from areas traditionally used for rituals.

The trade liberalization policies initiated in the 1980s have attracted investors to regions with gold reserves, creating conflict between the few who benefit from the external investment and the remaining poor who often suffer as a result of the investment. The resource conflicts are creating both out-migrations and in-migrations from mining regions. Migration is often thought of as an ecological *safety valve*, where the pressure from a lack of resources causes people to move from one area to another in search of basic necessities, such as potable water, land, and food (Charnley 1997). However, native peoples are often in conflict with the displaced people who settle in their territories. In urban areas where unemployment is high, young displaced people often become involved in and fall victim to crime and prostitution.

Child labor is another form of vulnerability that is linked to mineral exploration in the region. Children younger than 15 years old are widely engaged in mining activities (Madulu 1998). Resource and land scarcity due to mining activities, exacerbate the chronic inequity among social groups, thus heightening the threat of both civic strife and

international conflict (Rees and Westra 2003). From an environmental justice perspective, uncontrolled mining activities, such as the use of hazardous chemicals, threaten aquatic and terrestrial ecosystems and the public's health in the catchments of Lake Victoria. The major environmental problems associated with mining in the region include dust, mine pits and cracks and collapse of buildings due to mine induced explosions and pollution of water sources from mercury and cyanide. High levels of heavy metals in Lake Vitoria, for instance, are attributed to industrial, agricultural and domestic wastes and effluents (Kishe and Machiwa 2003).

A study conducted by the National Environmental Management Council of Tanzania NEMC in 1994 on heavy metal pollution in open pits in gold mining areas in the lake zone revealed that mercury levels were significantly higher than the permissible level of 1 mg/L in drinking water. In addition, both large scale and artisanal mining contributes to pits that have caused the destruction of land, making it unfavorable for agriculture and livestock production. Environmental pollution is but one example of injustice that affects the poor who lack the means to respond to health crises and ecological disturbances. Furthermore, the government has been reluctant to compensate people adversely affected by mining operations (Lissu 2001)

Environmental degradation, pollution, displacement and child labor are intertwined symptoms of a misguided global economic development paradigm that is itself a product of injustice (Rees and Westra 2003). Tensions have caused conflicts between mine-workers, host communities and investing companies, as well as companies versus artisanal miners. The conflicts emerge as an outcome of people's displacement, being relocated to resource-deprived land and lacking social services and land ownership

critical to psychological and physiological health (Lissu, 2001). In other words, the expansion of mining in the region has made it difficult for people to secure and own lands that could have been used permanently for agricultural activities. Consequently, food shortage, famine, poverty and intensified environmental degradation are all forms of resource violence that are affecting people but hardly quantified.

The lecturer at the University of Dar es Salaam—Dr. Adolf Mkenda, was quoted by the online daily newspaper *The Guardian* saying, “Mining and oil drilling cannot guarantee sustainable growth unless the resources’ rent is collected and re-invested into alternative forms of productive capital.”²²⁵ The minister suggested that countries that attract Foreign Direct Investments (FDIs), including Tanzania, are endowed with abundance of natural resources, but suffer from low taxes imposed to investors and opaque contractual arrangements that undermine the possibility of collecting and re-investing the rents. These conditions have continued propagating the theme of rich in natural capital, poor in economic development accompanied by low human development index.

EXOTIC SPECIES IN LAKE VICTORIA

Mwanza region is experiencing the spillover effects of exotic species introduced in Lake Victoria. The lake has been subjected to rapid ecological changes caused by anthropogenic eutrophication, exotic species, intensive fisheries activities, and the strangling spread of water hyacinths (*Eichhornia crassipes*) (Von Kaufmann 2007).

²²⁵ Source: How extractive industry harms Tanzania, Africa the paper (*The Guardian*, May 31, 2009) Paper titled “Capital, Science and Technology: The Missing Link in Africa at the 46th Africa Day Seminar in Dar es Salaam, Tanzania.

Invasive species are introduced both intentionally and unintentionally. The introduction of an invasive species, including Nile perch (*Lates Niloticus*), in Lake Victoria in the 1950s for commercial purposes, was based on poor calculations that ignored externalities and has pushed populations of native species to near-extinction. The management of resources in Lake Victoria has been influenced to the large extent by the presence of Nile Perch, which caters to the international market (Matsuishi, Muhoozi et al. 2006; Njiru, Kazungu et al. 2008; Msuku, Mrosso et al. 2011). The Nile Perch as an economic and cultural symbol in the region, and there is now a statue of it in the city garden at one of the intersections in the city center making it an attractive and aesthetic scenery to visitors in Mwanza town (Figure 18).

This exotic species, however, has further intensified fisheries activities and massive



Figure 18: A Nile Perch statue in Mwanza City

discharges of untreated industrial waste. The introduction of fish species in the Lake Victoria basin, like elsewhere in the world, has both positive and negative implications. More often, however, the costs outweigh the benefits. These exotic species eliminate native species through competition, alteration of gene pools, and ecological imbalance (Okemwa and Ogari, 1994; Ogutu-Ohwayo and Hecky, 1991). The new species were added based on their beneficial impacts while, to a great extent, ignoring both short and long term adverse impacts. The Nile Perch were introduced for various reasons: first,

increasing fish yield, and secondly, eliminating potentially harmful exotic species *Haplochromis*, and third as sport fish (Achieng, 1990; Ogutu-Ohwayo, 2004).

The Nile Perch became more conspicuous and pronounced in early 1980s in the lake and dominated the local markets. Plentiful prey and small harvesting rates due to the low level of fish industry at that time contributed to the big catches and sizes of Nile Perch. Nile Perch emerged as a cheap and easily accessible resource in the region. At first consumers were excited to have a different palatable species, but the perch's large size and oily nature were initially unappealing. People started thinking about other native species or species that existed before Nile perch was introduced. Unfortunately, the perch's rate of reproduction was higher than the consumption rate, which contributed to an ecological shift in Lake Victoria due to the carnivorous nature of Nile perch.

Nile perch altered the biodiversity system of the lake and the population of other valuable native species, besides Tilapia. The size and weight of Nile perch was enormous, reaching a maximum length of two meters and weighing up to more than 100 kilograms, the Nile perch's size allows it to consume the majority of other species in the lake, and has thus contributed to the scarcity and extermination of these populations. Reports of the Nile Perch's interruption of the food web have been observed in countless cases. The original 350-400 species of native fishes in the early 1900s are now fewer than 200 (Eggert and Lokina 2004), including 37 species of crab. About 150-200 of the endemic fish species, most of which had not been fully described by scientists, are now gone (Ogutu-Ohwayo 1993; Kitchell 1997; Goudswaard, Witte et al. 2002; Verschuren, Johnson et al. 2002). Almost all industries established in the region, are aimed at external markets, thus shifting lake resources from subsistence requirements that had been met up

to late 1980s in the region to an export-oriented economy. The reduction and elimination of native species, which were traditional sources of food and trade among local people, further lead to a decline in the economy, social opportunities, and health of native peoples. Verchuren et al (2002) argues that the evaluation of recent ecological changes in the context of aquatic food-web alterations, catchments disturbances and natural ecosystems variability has been hampered by the scarcity of historical monitoring data.

Incipient resource scarcities represented by everything from the collapse of fish stocks to the transformation of communities can be traced mainly to the overwhelming demand of European consumers for products such as Nile Perch (Rees and Westra, 2003). There was an expansion of the fish industries by the end of 1980s aimed at harvesting Nile perch and processing fillets for export to Europe, Asia, and the United States. This was the turning point on the size and catches of Nile Perch obtained in the Lake Victoria. Likewise, most of the fish export industries built in the late 1980s and 1990s are located on the lake shore and have ecologically and economically (positively and negatively) impacted poor communities. There are about 30 factories in the three countries surrounding the lake, employing about a half-a-million people and worth about US \$400 million (Von Kaufmann, 2007). Nile perch have so far resulted in tremendous increases in the quantities of fish landed (Hecky, 1991). The proportion of Nile perch export values to total exports rose from 1.4 percent in 1993 to 12.7 percent of total exports in 1998 before dropping to 9.5 percent in 1999 (Kulindwa, 2002). Fishing departments in the Victoria basin report that from 1986-1991 and from 1991-1997, there was a 28 percent annual increase in Nile perch catches, equating to an increase from 133,097 to 169,890 tons of fish catches per year (Mailu, 2001). Prior to the Nile Perch

boom, resources from Lake Victoria were not highly valued by outsiders or violently contested, because they were unsuitable for large-scale production. Local communities survived by fishing native fish species. By the 1980s, fish-export became one of Tanzania's highest sources of foreign exchange in Mwanza after gold.

As a result, the focus on export of Nile perch and the decline of native fish populations have reduced important sources of protein and income sources for the communities in the proximity of Lake Victoria (Geheb, Kalloch et al. 2008). The magnitude of protein deficiency caused by this decline and their related health consequences are yet to be quantified. What is evident is that the massive production of fillets diverted subsistence fish management practices to corporate management, and thus created global politics and power structures in the region that has become vulnerable to different economic transformations and cultural changes. The corporate interests and production of Nile perch marginalized the production of other fish species such as tilapia, diminishing the cultural and economic potentials. The higher demand for the Nile Perch production transformed the Lake Victoria ecological and management systems, with most of the efforts directed to Nile Perch which accounts for more than 50 percent of the fish trade in Lake Victoria. The large portion of Nile perch harvested is intended for international markets, and local fishermen competing to secure fish resources for industries. These conditions have resulted in reduced amounts of fish fish traded and consumed locally.

Investors with large capital have outpaced small-scale fishermen, and the ones who have survived in the business have to supply their catches directly to the industry. This situation is described by Brechin and Kempton (1994) who argue that market driven

economies are in conflict with people's survival and the ability of nature to regenerate (Humphrey et al ed. 2003, pp.330-331). The expansion of fisheries in the region has led to an expansion of industrial construction, forcing some farmers to migrate further from the lake. Others migrate to urban areas and become involved in prostitution, subjecting themselves to the high risk of HIV infections. The migration and mobility of fishermen and other petty traders has created what is famously called "sex for fish", a symbolic metaphor that is used in many different ways—for instance in Tanzania the practice is known as *Ngono samaki* (literally exchanging fish for sex).

What is seen is that Lake Victoria is now a subject of multiple stressors effect that is caused by introduction of Nile Perch. These effects appear to be indirect, but they are significantly influenced by the harvesting, processing and shipping of Nile Perch. These problems include accelerated eutrophication and toxic contamination of the lake which is caused by fillet industries. All these, when combined with other environmental alterations, affect the entire ecological system of Lake Victoria. This was highlighted during the 8th International on Conservation and Management of Lakes in Copenhagen, Denmark in May 1999, which highlighted factors contributing to the eutrophication and toxic contamination of the lake. These reasons include the presence of industrial discharge, mining discharge, pesticides and fertilizers from agricultural activities, as well as surface and, urban run-off, with potential dangers of acidification of the water from chemicals, such as sulfur oxides and nitrogen oxides. Thinking systematically, for instance, mining and fishing impacts are not entirely disconnected, rather they are connected and affecting environment and economic conditions. In 2008 for instance, Turkey rejected more than 16,000 kg of fish fillet from Tanzania after tests revealed

mercury contamination, mainly from mining activities in the proximity of Lake Victoria (Speigel, 2009). These are deposited into the lake through soil erosion and rain water runoff of fertilized soil, leading to an accelerated growth of weeds, toxic blue-green algae, and diminishing the natural aging process of the lake. This has also led to the accelerated growth of another invasive species: the water hyacinth.

The nutrient loading in Lake Victoria due to industrial expansion is enormous, providing positive feedback to algae and water hyacinth. Water hyacinth is beyond the scope of this discussion, however as one of the invasive species it will be briefly mentioned to explain how it is contributing to ecological and social impacts in the basin. The literature indicates that the species was first introduced in Africa in 1870, and first observed in Lake Victoria a century ago. The water hyacinth, for instance, was absent as late as 1980s, but came to grow into a devastating situation in the early 2000, adding another stressor to the lake ecosystem. The rapid spread of water hyacinth has economic, social, health and environmental consequences. Nutrient loading in terms of nitrates and phosphates from municipal wastes and agricultural activities increased water hyacinths biomass accumulation thus threatening other aquatic in the lake.

Large mats of water hyacinths posed major obstruction to water intakes, transport and fisheries operations. Delays in delivering fish catches resulted in deteriorations of fish quality, and to avoid spoilage, operations had to carry ice, which increased operational costs. It turned the water green and dirty, making the supply unsuitable for drinking and other domestic use. Reductions in oxygen in the water created an unsuitable environmental for fish survival, subsequently reducing species diversity and quantity (Njiru, Othina and Wakwabi 2002).

The water hyacinths became a breeding ground for mosquitoes and snails, the agents for malaria and bilharzias (schistosomes), which have been diagnosed among patients visiting health centers in Mwanza. In other words, the health effects associated with water hyacinths was increased patients and costs to the overburdened health sector that already been overwhelmed by challenges, such as HIV/AIDS.

Likewise, the quality of water obtained from Lake Victoria was also compromised by pollutants emanating from industries, agricultural activities and municipalities. Efforts by local, regional, and international actors managed to control the water hyacinths problem until recently where studies are showing the increased growth of water Hyacinths.

Nile perch and other species are linked with invisible violence through the environmental degradation of aquatic resources upon which rural people depend intimately for their livelihoods. Local peoples are therefore required to move away from their traditional homes or must try to find jobs which are often low paying in urban areas and fish landing sites, leading to risks of disease infection, poverty, and malnutrition. Large industrial actors also exploit lake resources for external markets, resulting in scarce fish products for the local market, thus depriving protein in the diet of the local population (Geheb, Kalloch et al. 2008). The expanding mining activities have also health and other social implications. Mobility of people and shipping of goods along expanded trucking routes throughout the region have also contributed to, among other things, increased incidences of HIV/AIDS (Clift, Anemona et al. 2003; Desmond, Allen et al. 2005).

VULNERABILITIES

The ecological manipulation with unidirectional changes to the industry aimed for European consumers has had serious unintended and incalculable consequences in local regions, such as decline of protein in the diet in local communities. The decline of fish species in Lake Victoria and the expansion of fillet industries for the international market have reduced sources of cheap protein diets in the region. The problem is further aggravated by the limited ability of people to maintain livestock due to increased urbanization and ecological changes that have reduced the quality and quantity of grazing fields. The absence of

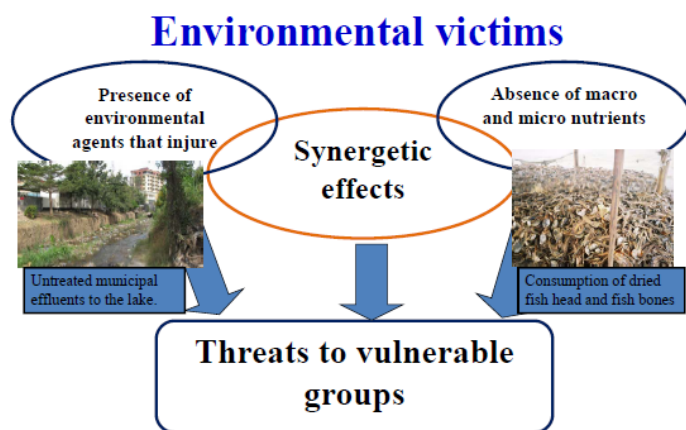


Figure 19: Risks and synergetic effect in the Lake Victoria Basin

environmental macro- and micro-nutrients could lead to conditions such as protein-energy malnutrition (Williams, 1998) as well as further aggravating opportunistic infection and symptoms for people suffering from HIV/AIDS. People in the region are also exposed to a synergetic effect mainly due to the consumption of polluted fish and untreated lake water, or living in areas with poor sanitation (Figure 19).

The expansion of extractive industries in the region, and their failure to incorporate externalities in their programs, has led to adverse health and environmental consequences. Profit is calculated based on industrial operation costs, which are highly

influenced by factors such as technology, labor and scientific management practices. The production basis leads to concomitant intensification of the ecological externalities of extractive industries causing both visible and invisible violence upon people and ecosystems (Peluso and Watts 2001). For instance, what is seen in the region is that the Nile perch has transformed what were relatively “low value” open-access and common-property resources into resources with such high values that people will use violence in order to secure them (Peluso and Watts, 2001 p.268).

The economic challenges in Mwanza and factors such as HIV/AIDS are increasing the population of orphans. Some children have lost one or both of their parents, while others are born and abandoned. These children struggle in many different ways. Some live in urban areas and act as beggars (Lockhart 2008), and others take different kind of jobs which put them in risky environments for physical abuse, and they become susceptible to diseases such as HIV/AIDS. Fish landing sites are a danger to fishermen, because of the risks of HIV/AIDS transmission and loss of lives due to boat or drowning accidents (Kamanzi 2008). Kamanza further notes that fishing is a risky activity with fishermen acknowledging that death by drowning could happen while on duty. Fishermen see no difference in death caused by accidents in Lake Victoria or by HIV/AIDS due to unprotected sex. Therefore, fishermen are more likely to have a devil-may-care attitude, ignoring the use of condoms suggesting that even though they can escape risks of HIV/AIDS, they hardly can avoid the risks of drowning. For them there is no safe environment on or off the lake, and the despair is compounded by the nature of their work. Fishermen work long hours with little financial gains due to the contracts they

have entered into with boat owners and money lenders who give working capital to exploit fish resource to be supplied to fish industries in the region (Kamanzi 2008).

The lack of and the increased costs of medical services are pushing communities to explore alternative sources of health care for the increased population in need of such services. People in the region are seeking medical attention for communicable diseases, regenerative diseases, infectious diseases, pollution related illnesses and HIV/AIDS and its opportunistic infections. In fact, these multiplicities among health problems create conditions for a pluralistic medical system of different actors in the region. Mwanza presently has various groups of health care providers claiming to have different specialties including individuals capable of improving immune systems, restoring and treating erectile dysfunctions, mental illnesses, and opportunistic illnesses for people infected with HIV.

Changes happening in Mwanza show that health conditions and medical practices deeply mark the relationship among ecological manipulation, environmental justice, people's livelihood, health and medical practices. The health burden in Mwanza has by far surpassed the abilities of existing medical facilities, and communities of traditional healers see this as an opportunity to intervene. Healers are well-positioned to observe the ongoing health changes, and reflect on their cultural expressions and relationship to local definitions of health and healing. However, the expansion of farmlands along Lake Victoria causes the decline of macrophytes used for medicinal products. Studies in the region indicate that more than 60 percent of macrophytes in Lake Victoria have immense ethno-medicinal value (Lyaruu and Eliapenda 2002).

CONCLUSION

Mwanza emerges as an interesting case in examining how socioeconomic and ecological changes are shaping its health and medical practices. Intensive agricultural activities have not only lead to the aforementioned ecological problems associated with nutrient loading, but have also threatened soil fertility, food security, and productivity. Decreased water quality due to solid waste, pesticides, fertilizers, herbicides and industrial pollution flow into the lake has led to the rise in water borne diseases for which there is not adequate medical care available.

The ecological problems and health challenges in the basin are aggravated by conditions that produce environmental injustice and to a large extent undermine public health. Contemporary public health must therefore encompass the interrelated task of reducing social and health inequalities by achieving health sustaining environments. Studies have indicated that the prospects for future health are increasingly dependent on the processes of globalization and varied global environmental changes mainly influenced by human's economic activities (McMichael and Beaglehole, 2000). Addressing health challenges as McMichael and Beaglehole note requires approaches that take "a broad view of the determinants and, indeed, the sustainability of population health. This is an ecological view of health: an awareness that shifts in the ecology of human living, in relation to both the natural and social environments which account for much of the ebb and flow of diseases over time." (McMichael and Beaglehole, 2000) Health challenges in Mwanza are numerous, and in the absence of preventive measures more curative interventions will be required.

Local, regional and global actors have different roles in reversing the degradation in the basin and building physical and social infrastructures for sustaining social and ecological conditions. Any interventions, however, require collaborative efforts in understanding the multiple-stress effect in the basin. A good indication for intervention is that different local and international agencies realize the magnitude of ecological problems facing communities in the Lake Victoria basin. Some interventions are already in place to reverse ecological problems and there are some positive changes observed in the basin. For instance, through scientific and physical interventions, the amount of water hyacinths has been reduced dramatically. The Beach Management Units (BMU) to ensure good practices of harvesting resources are in place in three countries Tanzania, Kenya and Uganda. Numerous studies are underway to examine the effectiveness of institutions governing resources in the Lake Victoria basin. The establishment of BMU is one example of the regional efforts to ensure restoration of ecological systems while maintaining the livelihood of the people in the region (Mkumbo, Nsinda et al. 2007; Njiru, Nzungi et al. 2007).

Still, environmental and social problems experienced in the basin are obviously vast and complexly interrelated. The interventions to address these multiple problems require a holistic approach that will address ecological problems while ensuring that social conditions are maintained. In order to reverse problems in the basin, a new approach is required, in which supporters of extractive industries offer solutions to the social, economic, ecological, and health problems they cause and are in turn affected by. Failure to take decisive and effective measures will aggravate the problems thus making lives of the people unsustainable in the basin and beyond through international circles.

These intertwined economic and ecological changes and their health implications are defining healers' responses to health crises in many different ways. Traditional healers form an important group that is central to the established networks in the region. This group has had a key role in establishing power within communities and with kin relationships for many centuries. The role of traditional healers in Mwanza is recognized by the literature showing that this group is adapting to the changing social structure in the region (Wijsen and Tanner 2002) as well as responding and adjusting to new emerging health conditions. In other words, the field of traditional medicine is not static and is shaped not only by epidemiological factors, but by social, ecological and economic conditions. Healers in Mwanza have been responding to environmental and health challenges by adjusting their strategies. At the center of these challenges, are healers who are sought to provide immediate solutions to economic problems, health challenges, and security affairs. They are themselves subjected into vulnerabilities of their own. In the next chapters I discuss factors contributing to the increased demand of traditional medicine, while contrasting them with factors that inhibit its uses.

PART II CHALLENGES AND CHANGES IN HEALING PRACTICES

CHAPTER 6: HIV AND COMMODITIZATION OF HEALING ON AN EXTRACTIVE FRONTIER

THREE DECADES OF HIV/AIDS

Sukuma version	English translation
<p><i>Basatu wenubu tuwangalilagi bakusataga abanhu</i> <i>Bakukondaga sana na bunela bayucha duhu</i> <i>Angalilagi abasumba na banhya, lyaponyiwe ikula lya wingi.</i> <i>Angalilagi abasumba baluki na banhya Buking'wi lyagumilwe ikula lya wingi tukushila noyo.</i> <i>Busatu wenubu tuwangalilagi bakusata abanhu bayokonda bayucha duhu.</i> <i>Mpaga nu dokta mkubwa akapima ukumya,</i></p> <p><i>Petro wandya kushingisha Marekani akapima Ni Nairobi akapima itupilaga isata.</i></p> <p><i>Tukugulajiwa, twiyangalile Ahasante sana bana bujora ng'wabeja kunikaribisha ukumahoya, Padri Sandu nangisije mimbo mkulangh'anaga abanhu nubuoovu tubupunguje Tulashika ung'wigulu parokia baba nifurahishe nane Bujora kubatakatifu banizilile.</i></p>	<p>Be careful with this disease, people are getting ill They become emaciated like sisal fibers They die in large numbers You boys and girls, the disaster is on us.</p> <p>Watch out you teenage boys and girls HIV/AIDS has spread widely, and all will perish Be careful with this disease</p> <p>They weaken, then they die Even when he tested Peter, the specialist was amazed He called Peter, and shook his head. Again Peter was tested in the United States. Even in Nairobi he was tested, but the disease couldn't be cured. We will fall, we should be careful Thanks to Bujora for inviting me to this important discussion. Father Sandu I have composed songs to protect people, and that we should lower our sins</p> <p>We will be taken to heaven, and Parish Father let me entertain this blessed place, because you invited me.</p>

Song by Mubi Makemo June 23, 2007 Bujora-Kisesa

The song above was recorded from a healer and *ningi* (song composer and leader of a dancing group) who was invited to perform at *bulabo*.²²⁶ It captures in detail the perceptions associated with the HIV/AIDS epidemic among healers. The healer brings a message to the people about different aspects of the HIV/AIDS epidemic, including the magnitude, symptoms, vulnerable groups (especially young people), as well as the responses by local and international medical practitioners. The song also tells of healers' roles and their need to be recognized and be involved in preventive programs. Despite lamenting the threats associated with the epidemic, the healer feels that his message can be best delivered while people are entertained. He values the invitation to participate in the discussion about the epidemic. The song's message also shows the multiple roles that healers can have in responding to the epidemic.

Available studies have paid particular attention to how healers can provide medical therapies to people affected by HIV/AIDS (Homsy et al. 2004; Ngalula et al 2002). Other roles that healers have in communities, such as sensitizing the public about HIV/AIDS, are a lower priority. Acknowledging and understanding traditional healing practitioners and institutions now appear to be viable and urgent steps to assist national and international programs in efforts to combat HIV/AIDS (Campbell and Mzaidume, 2002). This chapter discusses the relationship between HIV/AIDS and traditional medicines in Mwanza, Tanzania by capturing narratives from patients as well as

²²⁶ *Bulabo* symbolically represents the Feast of Corpus Christi, a Catholic ceremony to celebrate the Eucharist. In the ceremony, flowers are thrown at the body of Christ at intervals during a long processional walk. The Feast of Corpus Christi is called *Bulabo*, which means "flowers" in Kisukuma. The ceremony coincides with the beginning of the Sukuma dance seasons between June and August after the harvest of local crops. It is celebration and leisure after people have been freed from farm activities and may celebrate their harvests. During this period, groups of dancers perform and compete through songs and kinds of acts (Bassire, 1997).

traditional healers and biomedical practitioners. This work aims to illuminate how the epidemic is defining the field of traditional medicines. I interviewed healers in order to determine their perceptions and practices in response to HIV/AIDS. Different aspects, viewed as a matrix, were examined, including: the common symptoms that are associated with HIV/AIDS, the factors that contribute to the disease's transmission, the different intervention measures aimed at providing cures for infected people, the support mechanisms ensuring infected people receive necessary medical care, the support they receive from the government, and the collaborative efforts between healers and government agencies.

Studies have demonstrated the ways in which HIV/AIDS infections are widely defining the position of traditional medicine (Nelms and Gorski, 2006). There is a shift in the discourse and in local practices, as well as a shift in transnational discourses and practices of intervention. Various studies examine how the epidemic is shaping the localized healing practices within particular nation-states (Janzen, 1978; Taylor, 1992; Waite, 1992), and the way in which the epidemic links the transnational and cross-border social aspects of healing practices (Farmer et al. 2001). Contemporary discourse considers the extent to which multiple conceptual and therapeutic frameworks intersect in the lived experiences of epidemics such as HIV/AIDS (Campbell, 1997; Peltzer et al, 2006).

During the early 1980s, which were also the final years of the Nyerere presidency (1961-1985), Sungusungu vigilantism (Chapter Four) spread in different regions and coincided with the emergence of the HIV/AIDS epidemic. Initially, Tanzanians heard about HIV/AIDS illnesses in the neighboring country of Uganda. By 1983, cases of

HIV/AIDS were reported in Kagera, a region in North Tanzania bordering Uganda. The war between Uganda and Tanzania (1978-1979) and the movement of people across the region are said to have exacerbated the spread of the epidemic. By 1986, almost every region had reported an incidence of HIV/AIDS. This was a new disease with new and complex symptoms that hardly responded to either biomedical or traditional therapies. New symptoms and modes of HIV transmission created dilemmas and confusion, just as it was doing in the United States, where various symptoms confused medical practitioners (Bayer and Oppenheimer 2000).

The former Tanzanian president, Benjamin Mkapa, recognized the impact of the disease and declared “HIV/AIDS a national disaster.” In December 2000, Mkapa announced the establishment of the Tanzania Commission for AIDS (TACAIDS) via Parliamentary Act No.22, of 2001. The purpose of TACAIDS was to provide leadership to coordinate different stakeholders and projects aimed at combating HIV/AIDS. The current President, Jakaya Kikwete, has been at the forefront of support for programs to alleviate major diseases that are the leading causes of morbidity and mortality in Tanzania. On April 28, 2009, President Kikwete, was joined by representatives of the United States Aid Agency (USAID) to launch *Angaza Zaidi HIV/AIDS* (“Pay more attention to HIV/AIDS”). This program was part of an effort to curb the impact of a complex of illnesses. The mission was funded by the government of the United States, through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). The program has allowed many Tanzanians to receive health and medical services, such as testing, counseling, treatment and care, and has allowed others to pursue preventative care. President Kikwete stated that a Tanzania without HIV/AIDS is possible (*Tanzania bila*

Ukimwi inawezekana) through such programs.²²⁷ Kikwete himself participated in a campaign that encouraged people to voluntarily undergo counseling and testing. The President's support for such a program had a dramatic effect in Misungwi District in Mwanza; many people volunteered for testing and counseling. The surge in volunteers for tests that followed Kikwete's participation in such a program indicates that political support is needed to spearhead efforts to curb HIV/AIDS (De Waals 2006).

Mwanza is fertile ground for HIV/AIDS transmission to occur. Mwanza neighbors the Kagera region at the border between Tanzania and Uganda. This area is where the first cases of HIV/AIDS were reported. As shown in previous chapters, the region has undergone significant change in economic activities. For instance, Mwanza was among the major growers of cotton until the 1970s. In the 1980s, the region transformed into an industrial economy widely dominated by mining and fishing industries. The transition in economic activities has created a wide range of problems in the region, including poverty, the burden of diseases, and the gap between the poor and rich. Despite different efforts, both medically and politically, and at local and international levels, HIV/AIDS continues to affect many people in Mwanza, just as it does other regions in Tanzania.

In Mwanza and other "frontier" communities, a massive influx of human labor, combined with low levels of health infrastructure, has created conditions where HIV/AIDS can flourish. Traditional healers are often the first, intermediate, or last responders to this health and social crisis. Mwanza is among the Tanzanian regions with

²²⁷ Source "President Kikwete Launches PEPFAR Testing Campaign on May 4, 2009 accessed on April 1, 2011 from http://tanzania.usembassy.gov/pr_05042009a.html

the highest incidence of HIV/AIDS. Economic conditions and a rapid influx of migrant labor to Mwanza have impacted both the spread of HIV/AIDS (Lockhart, 2008), and the access to health care services (Mshana et al. 2006). The growth of mining and industrial fishing activities, together with income inequality, intersect to encourage unhealthy behaviors among the most destitute, including a rise in the incidence of *ngono samaki* (literally “sex for fish,” or prostitution as a subsistence activity). In addition, the prevalence of people with poor immune systems due to malnutrition and inadequate healthcare services is setting the stage for severe HIV/AIDS symptoms (Hunt, 1989; Gould, 2005).

The breakdown of HIV/AIDS rates in Mwanza’s communities, temporally and spatially, illuminates further geographic and livelihood-related patterns. In 1992, the regional prevalence rate was recorded at 2.5 percent for the population aged 15-54 years, with high prevalence rates for roadside settlements at 7.3 percent and 11.8 percent for the city of Mwanza (Lockhart 2002). Clift et al. (2003) note that in 1993, the prevalence of HIV was higher in artisanal mining settlements than in other rural settlements in Mwanza. The prevalence rates for the age group 15- 24 years were 15 and 23 percent for males and females respectively in mining settlements. In rural areas, for the same cohort, the prevalence rates were 2 percent of males and 3 percent of females. However, according to Clift et al., high prevalence rates were also recorded at 5 and 9 percent for males and females respectively. In 1995, the HIV/AIDS prevalence rate in the shoreline settlement in Magu district was 10.9 percent for men and 10.7 percent for women, compared to 3.8 percent in other rural areas, and 7.7 percent in the roadside population (Mwanuzi, 2006).

An interview at a Misungwi district hospital with a single mother and patient in her early 20s who was receiving antiretroviral drugs demonstrates the risky environment in one of the fish landing sites in Mwanza.²²⁸ She lived in Kome Island and was involved in *kuuza dagaa* (selling sardines in local markets), the job she had to abandon due to illness. She was not worried at the first when she developed some symptoms in early 2009, including a rash on her head, diarrhea and body wasting. She had a boyfriend who was a fisherman who had also developed some rashes on his body. She felt they were just temporary illnesses. She lost contact with her boyfriend and was later informed by her friends in the island that he was seriously ill, although no one told her the cause of his illness.

She recalled that the symptoms persisted, including regular fevers, rashes on her head, chest pain, difficulties in breathing (*kifua kubana*), and itching on her genitals. Other symptoms included *nywele kuteleza* (thinning and loss of hair) and *ngozi kukwatuka* (pale skin). She became emaciated and too weak to walk. These conditions forced her to seek medical attention from a traditional healer, who was not helpful. She was told to undergo medical tests in one of the hospitals in Sengerema town, but the test results were not disclosed to her. She decided to travel from the island to stay with her brother in a different district, called Misungwi. Her brother advised her to undergo medical tests for HIV. The test results indicated that she was HIV positive, and she was

²²⁸ Interview, Kulamwa Mamba, Misungwi Hospital, Interview 22/06/2010

then enrolled in a program to receive antiretroviral drugs starting in December 2009 at Misungwi hospital.

She noted also that the ARVs had helped her regain strength, but she suffered some side effects, such as *mwili kufa ngazi* (body numbness). She sees the benefits of the drugs, suggesting that her condition has significantly improved and that she is able to work, even though she occasionally feels chest pain, *kifua kubana* (difficulties breathing), and *kiuno kuuma* (pain around her hips and lower back). She noted that when she first visited the hospital, she weighed 40 kilograms, but she has since gained 8 kilograms due to the medical and health care she received. She noted, however, that she initially felt embarrassed to be seen going to the hospital to receive antiretroviral drugs. As time progressed, she became confident and comfortable visiting the center for testing and receiving drugs. She recalled that there were many people on the island with similar symptoms and she suspected they were suffering from HIV/AIDS. She noted that many people were using this service (antiretroviral drugs), making a reference to the many people suffering from HIV/AIDS.

Everyone has his or her own story about HIV/AIDS. These stories are layers of multiple aspects that characterize societies and the ways in which the epidemic is embedded in economic activities, social relations, and medical practices. As of today, the international community, in collaboration with national agencies, is making efforts to discover better approaches that would help prevent further infections and ensure access to curative interventions. Despite the failure of both traditional medicine and biomedical treatment, the disease raised the profile of traditional medicine. Many people, out of fear and in a search of therapies, started consulting traditional healers. The lack of either a

cure or a treatment further added suspicion about the causes among people in the region. They blamed witchcraft, the historical cause for incurable diseases with unexplained origins (Lwihula and Dahlgren 1993; Yamba 1997).

Traditional healers and their clients are at the heart of the lived experiences of the transformations taking place in Mwanza. Traditional healers have long played an important role in Mwanza, practicing herbal healing and divination rituals that stem from historical, cultural and ecological adaptations. With their knowledge of local plants and Sukuma ancestral beliefs, together with their expertise in providing remedies and long term care, healers are credited with positively influencing social cohesion (Wijsen and Tanner, 2002, 2006; Milambo, 2004). However, this social structure is changing due to an influx of diverse groups of healers.

Mwanza represents a strategic site to examine and interpret the relationship between political, economic, and environmental change and traditional healing practices. Its particular challenges, drug use, HIV/AIDS, and an increasingly heterogeneous population, are giving rise to competition among healing practices. The atmosphere is ripe for new forms of strategic alliances between traditional healing practitioners and biomedical institutions. For such alliances to be effective, however, they must transcend oversimplified understandings of “Western” versus “African” practices. To that end, I look to critically engage and assess new articulations of “accompaniment” in global health circles, in addition to the actual practices of accompaniment that still characterize some traditional healing systems.

POVERTY AND HIV/AIDS

Poverty and HIV/AIDS are intimately connected and reinforce one another, creating vulnerabilities for marginalized groups. Poverty is an outcome that reinforces illiteracy, joblessness, homelessness, child labor, and HIV/AIDS infection (Boone and Batsell 2001). The poor are more vulnerable to HIV infections. They progress to full-blown AIDS rapidly, due a variety of factors: limited access to health care, medical care, and nutritious diets, stressful work environments, a lack of education, and overcrowded living environments (Farmer et al., 2006; Kalipeni, 2005; Stillwagon 2000; Whiteside, 2002). HIV/AIDS affects both men and women; however, the rate of infection is higher among women than men (Urassa, Boerma et al. 2001). Women are more vulnerable because of gender inequality, socio-economic status, patriarchal systems in societies, and biological factors (Pilisuk, 1998; Lwihula et al. 1995). These conditions limit equal opportunities for women to make informed decisions (Farmer et al., 2006).

Furthermore, HIV/AIDS affects the most productive age group, thus exacerbating poverty in society and challenging families' attempts to support themselves. Poor communities can hardly provide basic health care services, thus exacerbating poor health conditions among low-income groups, as well. The disease also absorbs substantial amounts of finances and labor from relatives and other members of society, since ill people require continued and closely-monitored care (Naidu and Harris 2005). Studies indicate that when HIV/AIDS strikes, family members are challenged; their social systems are destabilized and new coping and response mechanisms must be created (Baylies, 2002). The health sector in Tanzania has remained financially constrained due to economic challenges, with rural areas most affected. Health centers in rural areas are

more often overcrowded and lack adequate facilities and medical experts. Financial support from the government has been capable of meeting only one-third of the requirements of the public system (Shiner, 2003)

The HIV/AIDS epidemic has continued to grow, simultaneously, with the increased rates of tuberculosis (TB). A large proportion of people with HIV/AIDS are prone to develop TB, due to their weakened immune systems (Farmer, 1999; Stillwaggon, 1998). Likewise, conditions such as congestion in cities, poor housing, lack of medical checkups, and inadequate health services increase the risks of TB infections.²²⁹ The data available indicates that TB cases in Tanzania increased from 11,703 in 1982 to 63,000 in 2010. The Minister for Health, Dr. Hadji Mponda, has noted that the increased cases of TB are attributed to HIV/AIDS infections. Hospitals are congested, and it is often hard to segregate individuals suffering from TB from other respiratory infections. I visited a hospital in one district in Mwanza. One patient I talked to was infected with HIV/AIDS and coughed continuously in a room occupied by patients with different medical conditions.²³⁰ While efforts have been made to deal with both HIV/AIDS and tuberculosis, concurrently, situations like the one I witnessed suggest there is a long way to go before effective solutions for these multiple problems.

In addition to the correlation between poverty and HIV/AIDS, studies have shown a positive correlation between infections and inequalities. Efforts to curb HIV/AIDS embrace strategies to deal with both poverty and inequality (Farmer, 2006) Both

²²⁹ Source: *Kifua Kikuu Sasa Tishio Nchini* (Tuberculosis is a threat in Tanzania) (Mwananchi online newspaper accessed on February 2, 2012 from <http://www.mwananchi.co.tz/habari/4-habari-za-kitaifa/18114>)

²³⁰ Field observation, Misungwi Hospital, June 22, 2010.

inequality and poverty are drivers for increased morbidity and mortality rates, particularly in societies affected by epidemics such as HIV/AIDS (Farmer 1999; Himmelgreen et al 2009). In addition, poverty and inequality are an outcome of structural violence. Vulnerable groups are hit hard by the consequences of structural violence. Berwick (2002) notes that denying modern health care for the poor is a *violence* that an international community and developed countries ought not to accept. He argues that the poorest people in the poorest settings can, if they are allowed and assisted, be involved in improving their health and can benefit from the most advanced drugs. Berwick suggests that poor countries can create social support that will improve health care delivery practices. Studies indicate people's health, and availability and access to health and medical care services, is determined by social structures that define levels of inequality and marginalization in educational and economic participation, and in access to and control over the society's health-related resources (Lynch, 2000).

In Tanzania, people die of HIV/AIDS --- not because of this disease, but because of other reasons, such as poverty or opportunistic diseases that can be treated or prevented with adequate access to proper diets and health services (De Waal 2006; Fassin 2006; Parker and Aggleton 2003). HIV/AIDS patients place a heavy economic burden on their families and on public healthcare sectors, draining resources necessary to support other essential social services. Tanzania is one among the countries that lack adequate health care infrastructure systems to adequately fulfill the health demands of their communities. At the micro level, there is always a shortage of trained labor in the medical field, and hospitals and clinics lack drugs and essential equipment. Reduced social service expenditure in Tanzania, a condition for SAPs, (Structural Adjustment

Programs), has caused medical profession layoffs and reduced salaries for those who are maintained in their posts. Strikes involving medical professionals are common conditions that exacerbate health challenges in Tanzania. Recently, medical doctors in major hospitals went on strike for about three weeks to demand improvement of infrastructures in hospitals, as well as increased wages for medical professionals.²³¹

The gap in access to social services is exacerbated by Structural Adjustment Programs (SAPs), Poverty Reduction Strategy Programs (PSRP), unequal exchange and trade regulations, WTO regulations and debts. A serious problem with these programs is their failure to recognize the immediate need of countries and local communities. With the change to neo-liberal policies and governing institutions, many countries were subjected to a situation in which they had to adhere to unequal trade. These institutionalized practices have had serious negative impacts; they influenced the rise in poverty and inequality. These conditions further exacerbate risks of HIV/AIDS infections, particularly in vulnerable groups.

STRUCTURAL VIOLENCE AND HIV/AIDS

The spread of HIV/AIDS and associated diseases is overwhelming and thus raises debates about the causes, including the combined effects of individual behavior and internal and external structural factors. Internal forces shaping the magnitude of HIV/AIDS include poor governance, corruption, internal exploitation, nepotism, tribalism, authoritarianism, military rule and overpopulation due to patriarchal attitudes

²³¹ Source: Doctors accuse PM office of sabotage accessed on March 7 from <http://www.thecitizen.co.tz/component/content/article/37-tanzania-top-news-story/20247-doctors-accuse-pm-office-of-sabotage.html> The online daily newspaper *The Citizen* March 3, 2012

and disempowerment of women (Benatar, 2002). Benatar suggests, however, that these shortcomings are, in one way or another, the outcomes of powerful external disruptive forces, such as unfair trade between developing and developed countries, acting over centuries to impede progress in Africa.

Until recently, Nguyen (2008) notes that efforts to address the HIV epidemic in developing countries had been almost exclusively focused on preventing HIV infection. A first generation of programs emphasized awareness campaigns such as “Information, Education and Communication” (IEC) in order to control deviant behaviors. The idea was to inform the public about risks and to control their behaviors, such as practicing safe sex. Another approach was to supply and distribute condoms as a preventive measure. The second generation of programs stressed the direct involvement of affected communities and advocated strategies such as “self-help” and “empowerment”. These programs embraced the solidarity of both the infected and affected to form support groups. Despite these efforts, people are infected in large numbers, thus raising questions about the effectiveness of such programs.

There are behavioral aspects that contribute to the infections. However, if examined closely, one could argue that the HIV/AIDS is directly and indirectly linked to *structural violence*. Structural conditions in economy, politics, and culture influence unhealthy sexual relationships, as they limit choices to avoid infections. The structural violence in this case occurs in many forms, such as land dispossession, lack of access to education and health infrastructure, structural adjustment policies, inequality, social marginality, domination of resources, failure to attend to preventable diseases, and other structural inequities which intersect to shape the character of HIV/AIDS (Farmer et al

2006; Pilisuk, 1998; Burris and Anderson, 2010). Pilisuk (1998) defines violence as unneeded suffering or death resulting from preventable human actions. It appears in society in the forms of child abuse, refugee neglect, AIDS among poor woman, domestic terrorism, slave trade in prostitutions, victimizations from environmental contamination, and abuse of children and women in sweatshops.

In some cases, structurally violent acts are invisible. These cases include environmental damage and resulting pollution, denial of human rights, and reduction of assistance for basic human needs (Farmer, 1996). People infected with HIV/AIDS are stereotyped; they experience multiple challenges with discrimination in employment, housing, public accommodation, education, health care, insurance, criminal justice, and legal services. Infected people experience abandonment, marginalization, and discrimination from their family members, their communities and their governments (De Waals, 2006; Fassin, 2006; Parker, 2002; Parker and Aggleton, 2003). This situation contrasts with human rights ethics that encourage rights and justice for all, despite physical conditions.

The HIV/AIDS interventions do not take into account the contributions and effects of state bureaucracies, health institutions, social environments or social and health policies that cause a disproportionate number of illnesses and deaths. Structural violence, as its name describes, is often built into the structures of society and can be exemplified by marginalization, exclusion and other social injustices toward a group of people (TACAIDS, 2005). Structural violence is characterized by a situation in which programs and practices do not include health for all. This violence is defined by the way in which

access to health care is constrained by the local, regional, and international political, economic, and health structures.

Structural violence, according to Farmer et al. (2006) affects access and adherence to effective therapy. As such the “roll-out” of antiretroviral drugs is increasingly seen as an inadequate solution to Africa’s health challenges. In Tanzania, for instance, only a fraction of people infected with HIV/AIDS are enrolled in antiretroviral programs. Likewise, those who are enrolled in the antiretroviral program do not necessarily adhere to the drug regime. In addition, numerous challenges associated with antiretroviral drugs are emerging.

STRUCTURAL VIOLENCE AND THE PUZZLE OF ANTIRETROVIRAL DRUGS

Different units in Mwanza City, including the Sekou Toure Regional Hospital, are now providing counseling, testing and distribution of antiretroviral drugs through a program that serves this small urban population (Leonard and Masatu, 2007). The use of antiretroviral (ARV) drugs has proved beneficial for reducing the lethal effects of HIV/AIDS and its opportunistic infections. ARV drugs have prolonged the lives of many who would have died (Benatar, 2002). The decreased number of deaths associated with HIV/AIDS is a positive sign. People living with HIV can still live normal lives and can resume work to support their families, societies, and the national economy as a whole. President Kikwete highlighted the benefits of antiretroviral drugs in his speech for World AIDS Day in the presence of the former President of the United States, George W. Bush.

In his speech, President Kikwete noted that antiretroviral drugs have helped infected pregnant women deliver and raise healthy, HIV-free babies.²³² The use of ARV drugs has reduced the number of deaths, even though the number of people living with HIV has increased (White, 2002). According to President Kikwete, over 13 million Tanzanians have been counseled and tested for HIV since July 2007, which marked the beginning of a nationwide campaign for voluntary counseling and testing launched by the president and his wife. By December 2010, about 740,040 people known to be living with HIV/AIDS were enrolled in care and treatment clinics. Of these, 384, 816 people received counseling services and antiretroviral therapy. In 2011, President Kikwete said there were 4,301 health facilities providing Prevention of Mother to Child Transmission (PMTCT) services (equivalent to 93% of all health facilities in Tanzania), and seventy percent (80,748) of HIV-infected pregnant women had received care and treatment. Fifty-seven percent (65,948) of all children born to HIV-infected mothers received medicines to prevent mother-to-child transmission of HIV.²³³

There are many positive outcomes from ARV therapies. Boone and Batsell (2001) note that the availability of ARV drug therapies allows sero-positive people to “live with AIDS.” However, questions arise: what are the short and long term impacts of antiretroviral drugs? To what extent are the availability, access, distribution, and prescription of ARV drugs embedded in the paradigm of structural violence? ARVs have emerged as the solution to the HIV/AIDS epidemic at international, regional, and local

²³² Source: (URT, 2005) Statement by H.E. DR. Jakaya Mrisho Kikwete, President of the United Republic of Tanzania on the World AIDS Day, December 1st, 2011, Ocean Road, Dar es Salaam accessed on February 5, 2012 from <http://www.tanzania.go.tz/hotuba1/hotuba/World%20AIDS%20Day.htm>

²³³ Source: <http://www.tanzania.go.tz/hotuba1/hotuba/World%20AIDS%20Day.htm>

levels. Yet bureaucratic and other forces mar the institutional framework governing the production, marketing, distribution, and access, such that the benefits can hardly be fully realized.

One of the healers interviewed in Butimba, Mwanza, noted that dealing with HIV/AIDS is complicated, saying, “The disease is widespread; people are not willing to reveal their status; *wanaona aibu* (they feel embarrassed) and are worried about being stigmatized. The antiretroviral drugs have helped, but these medicines do not eliminate the virus.”²³⁴ Despite public announcements encouraging the use of antiretroviral drugs, most patients lack access to them. In addition, many people do not know they have been infected. Those who are enrolled in the drug regimens experience treatment interruptions due to the unreliability of the drugs, side effects of the drugs, and fear of being stigmatized when visiting health care centers that offer drugs (Mshana et al., 2006). Further, the large pool of people infected but using ARVs can easily interact with the uninfected, thus increasing prevalence rates (Schwartländer, Garnett et al. 2000). Others have noted that access to antiretroviral drugs is a problem in itself, as it increases the overdependence on drug supplies, with benefits accruing to drug companies but not the people who are in need of the medicine (Biehl, 2010).

Unavailability, unreliability, inaccessibility of ARVS

Voluntary testing programs are hampered by structural obstacles, such as a lack of facilities and drugs required for the programs. Recently the Tanzanian online daily

²³⁴ Interview, Isaka Kale, Butimba Mwanza, February 10, 2010)

newspaper, *The Guardian* (June 17, 2011), reported that thousands of HIV/AIDS patients in various hospitals could not be tested due to a lack of reagents used to test for HIV/AIDS, including SD-Bioline, Facs flow solution, and HB. The reagents had reportedly been missing since the previous April.²³⁵ When the government tried to obtain the missing reagents, health officials realized one of the drugs had been “de-listed” by the World Health Organization (WHO). According to *The Guardian* article, the “de-listed” drug, SD Bioline (the life-prolonging drug), which is used by all Global funds recipients’ nations, including Tanzania, was phased out and deemed unacceptable due to its malfunction.²³⁶ Therefore, the government of Tanzania had to suspend its order because of the “de-listed” drug. Since there was no alternative drug, many people in need of testing services were affected. Yet, despite being phased out by the WHO, *The Guardian* (December 31, 2011) indicated that the de-listed HIV test kits (“SD Bioline”) were still in use in some health centers in Tanzania. Numerous adverse impacts are associated with the use of the defective kits, including elevated cases of infections. Some people test false negative. Thus, blood from HIV-positive people may have been given to others in need of transfusions, such as pregnant mothers. The use of de-listed test kits could escalate the spread of infection in both mothers and their unborn babies. If pregnant mothers have

²³⁵ Source: Crisis as HIV testing services halted, *The Guardian* online June 17, 2011 by Gerals Kitabu – http://www.ippmedia.com/frontend/functions/print_article.php?l=30223 accessed January 3, 2012

²³⁶ Source: WHO de-lists ARV Drug, *The Guardian* online December 30, 2011 - http://www.ippmedia.com/frontend/functions/print_article.php?l=36930 accessed January 3, 2012

been wrongly informed from faulty HIV/AIDS tests, they might inadvertently infect others, including doctors and their infants.²³⁷

Antiretroviral drugs are mainly distributed in urban areas where health centers are concentrated. However, rural areas are recipients of people with advanced stages or full-blown AIDS who decide to return to live with parents or grandparents. This situation taxes existing infrastructure. The working population is infected and has to rely on their retired parents and grandparents. Infected parents are also more likely to have children who are suffering from HIV/AIDS. In 2006, Mkapa established “The Benjamin William Mkapa HIV/AIDS Foundation,” a non-profit organization that supports programs that deal with strengthening HIV/AIDS prevention, care, and treatment. These programs serve communities in remote areas that are underrepresented in health care access.²³⁸ The epidemic has caused an increased number of orphans, with or without infections, as well as families, communities and governments in Sub-Saharan Africa that cannot provide the necessary resources to cater to their needs.

In terms of access, developing countries have a greater number of people who are infected with the virus who are also experiencing economic hardships. In spite of this reality, drug companies have resisted access to their drugs for those most in need in those countries. “According to UN figures, some 25 million people in Sub-Saharan Africa have AIDS or HIV but are unable to gain access to affordable generic AIDS drugs because of international patent agreements that prevent sales of cheaper generic drugs” (Delaet,

²³⁷ Source: Delisted HIV test kits still in use; *The Guardian* December 31, 2011 - <http://www.ippmedia.com>

²³⁸ Mkapa calls for more efforts to combat hiv/aids from ippmedia on may 29, 2010 <http://www.ippmedia.com/frontend/index.php?l=17193> retrieved January 10, 2011

2005, p. 112). Drug companies are accused of perpetuating structural violence, particularly when they are reluctant to reduce the costs or to allow other countries to manufacture generic versions of drugs. Developing countries see the drug companies' tactics as a way to use the epidemic to amass huge profits. In response, countries like Brazil and India have ignored patent rights and are now producing generic drugs. Together with other countries, they are challenging the patents imposed by Western countries at the expense of people dying from HIV/AIDS (Booker and Minter, 2001).

Even if ARVs are available, continued political will may be waning. Despite massive budgets worldwide to support distribution and prescription, political leaders are not optimistic about the control of the epidemic and feel that the approach is not a sustainable. Speaking at the launch of the Geita Gold Mine Kilimanjaro Challenge against HIV/AIDS 2010, the former Tanzanian President Benjamin Mkapa noted that, despite different efforts by local and international agencies, the problem shows no sign of disappearing.²³⁹ A statement from the United States' President, Barack Obama, echoed his argument. Obama acknowledged that the approach used to combat HIV/AIDS had proven to be ineffective, and that new ways were deemed necessary to reverse the impacts of HIV/AIDS.

In an article in *The Guardian*, President Obama suggested nations and organizations needed to find new ways of combating HIV/AIDS, rather than solely relying on antiretroviral drugs. He worried that international aid agencies may soon become fatigued with the spread of HIV in the African region. For every person currently

²³⁹ Source: Mkapa calls for more efforts to combat hiv/aids from ippmedia on May 29, 2010 <http://www.ippmedia.com/frontend/index.php?l=17193> retrieved January 10, 2011

using antiretroviral therapy, about three others are newly infected with the virus. President Obama asked African governments to undertake behavioral change initiatives with their citizens to reverse the endemic spread of the virus, because the current trend is both “unacceptable and unsustainable.” President Obama also noted that funds were not available to simply treat the many people already infected with HIV (*The Guardian* August 15, 2010). Obama suggested new approaches to facilitate access to treatment and to reduce infection rates.²⁴⁰

The provision of antiretroviral drugs has not been able to respond to the rate of new infections. Benatar (2002) argues that achieving this objective requires understanding and the ability to address the deeper social causes of pandemics. Newly proposed solutions must acknowledge the disempowering effect of the exploitation, discrimination and imperialism that characterize the current world system that reinforces local conditions and also escalates the magnitude of HIV/AIDS by creating populations vulnerable to infections, while limiting access to health and medical care.

The controversy about access and distribution of antiretroviral drugs provides the urgent need to examine how structural violence discourse is embedded in the political and economic structure of governmental and international agencies, and in the distribution and administration of the antiretroviral drugs. In recognizing the nature of structural violence in communities, different activist groups have advocated for more

²⁴⁰ Source: *The Guardian* on Sunday August 15, 2010 “We are treating AIDS like a woman treats his wedded partner” by Venansio Ahabwe, a regional commentator on social, political and economic issues based in Kampala.

awareness campaigns about HIV/AIDS, conducted fundraising campaigns, and asked and challenged drug companies to provide affordable drugs.

Adherence to the drug regimens

Access to antiretroviral drugs does not guarantee adherence to the treatment by infected people. The average rates of non-adherence to antiretroviral therapy, for instance, range from 50 to 70 percent in many different social and cultural settings. Risks associated with non-adherence are extensive at both individual and societal levels (Weiser et al, 2003). The lack of “social networks” in both national and international programs has rendered the molecular-based therapies less effective (Farmer et al, 2006). The magnitude of HIV/AIDS in Sub-Saharan Africa now requires trained community health care workers who will supervise care for AIDS patients within their home villages and neighborhoods (Kim and Farmer, 2006).

Adherence to the drug regimen has been closely correlated with viral suppressions, while non-adherence has contributed to the progressions of AIDS, with social and economic consequences to communities (Farmer, 2004). Yet, adherence to the antiretroviral regimen remains a challenge to improve the health of infected people. Farmer (2007; 2008) advocates for “accompaniment,” a process that involves close interaction that allows health care givers to monitor and supervise all necessary health aspects for patients infected and affected by HIV/AIDS. “Accompaniment,” which originally was anchored in the complexities of antiretroviral and tuberculosis remedy adherence, has come to be spoken of more broadly in terms of support for the sick who also suffer from poverty and illiteracy.

The success of this kind of program depends on factors such as infrastructure and trained personnel. Certain questions arise: what will be the key group that can support health care services offered to the patients, particularly those with chronic illnesses and those requiring prolonged drug therapies? The ARV drugs regimen provides an opportunity in which the social relations of healing are newly opened for reconfiguration across biomedical and traditional divides. Can healers' roles in the community influence "adherence" to the ARV therapy in Mwanza, a goal that has proved to be a challenge to AIDS care worldwide (Weiser et al, 2003)? Healers may play a role in responding to the HIV/AIDS epidemic due to their numbers and their close contact with patients.

Allen and Heald (2004) hypothesized that the pattern of adherence to medications would be different in developing countries, such as Botswana, than that in industrialized settings, and that "gaps in treatment" would be at least as significant as the problem of day-to-day non-adherence. A study conducted in Botswana to map adherence to antiretroviral treatment indicated that 21 percent of the population was willing to visit or travel to healers in the future for treatment of HIV infection (ibid).

In Mwanza, Tanzania, as it is in Botswana, adherence to ARVs treatments remains a challenge due to a number of factors. The magnitude of the HIV/AIDS health crisis in Mwanza has overwhelmed the existing biomedical facilities and medical professionals in Tanzania. As shown in previous chapters, Stangeland et al. (2008) demonstrated a traditional healer-to-patient ratio of 1:350-450, compared to a Western conventional medical practitioner-to-patient ratio of 1:33,000. The Tanzanian online newspaper, *Mwananchi*, indicates that the WHO recommends one medical doctor for

every 10,000 people in Tanzania. The current ratio is 1:28,000.²⁴¹ People who are infected or suspected of being infected with HIV/AIDS search for alternative therapies, knowing that there is no single curative intervention that has proven effective. Suppliers of traditional medicine have embraced the idea that no single therapy is effective to treat multiple conditions. Healers now advertise their medicine as capable of treating different multiple conditions, such as opportunistic infections in people suffering from HIV/AIDS.

THE SOCIAL CONSTRUCTION OF THE DISEASE AND CHANGES IT ACCRUES

The first case of HIV/AIDS in Tanzania was reported in the early 1980s. At the time, it was known by English patois slang names, such as *slim* (referring to loss of weight or the emaciating effect) (Mshana et al, 2006; Allen and Heald, 2004). Others called it *Juliana*, because people who were selling polyester shirts with the popular trade name, “Juliana,” came from Uganda in the early-1980s. These traders²⁴² were accused of carrying the disease from Uganda (the place where the first incidence of HIV/AIDS was reported in East Africa) to Tanzania. The disease, according to Kamanzi (2008), quoting Rugalema (1999:68), was named *Juliana* or *Magendo* affliction.

Therefore, the trans-boundary movement of people and goods not only allowed the transfer of merchandise; the new virus was traded, as well. While the merchandise

²⁴¹ Source: *Moi yafunga huduma za kliniki* (*Mwananchi*, Tuesday, January 31, 2012) accessed February 3, 2012 from <http://mwananchi.co.tz/news/4-habari-za-kitaifa/19858-moi-yafunga-huduma-za-kliniki.html>

²⁴² The business of *Juliana* shirts was considered profitable following the poor economic period in Tanzania that followed the war with Uganda, and when the socialist policies restricted, to the large extent, the flow of different goods into the Tanzanian market.

and goods reached few people, the virus spread quickly in almost every region of Tanzania. By 1987, almost every region had experienced cases of HIV (TACAIDS 2009). It is not surprising that Kagera Region, the administrative region along the border with Uganda and that experienced intensified human interaction at the time of war between Tanzania and Uganda in 1979, was the first to experience the devastating effects of HIV/AIDS (Lwihula and Dahlgren 1993). The Mwanza Region, which borders Kagera to the southeast, became an intermediate point in the spread of the virus throughout Tanzania.

The devastating symptoms associated with HIV/AIDS, and the subsequent deaths, created logics of naming and renaming as people responded to the dynamics of the disease. HIV/AIDS has been called *pembe nne* (literally “four corners” or “rectangle”.) This name reflected the ultimate outcome of HIV/AIDS: death (at the time before antiretroviral drugs were introduced), with the deceased placed in a rectangular coffin and buried in a rectangular grave (Mshana, Plummer et al. 2006). HIV/AIDS has not only changed how language is used to describe the condition. It has also changed the practices associated with burial and mourning.

Before HIV/AIDS, deaths were customarily linked to the elderly, infants, and accident victims. In the past, particularly in Sukuma Region, mourning took three days. People throughout the village would limit their activities, such as farming, until the deceased was buried. Prior to this crisis, carrying a hoe in the village when there was a death was a violation of the customary rules. This has changed because of the increased death rate; now those not close to the deceased continue with their duties, pausing only for burial.

Ngoma became another popular term used to describe HIV/AIDS infections. The term *ngoma* has various connotations in different social settings, including a drum or a traditional cultural performance and dance. Young men have also described women as *ngoma*. HIV/AIDS has also been described as *nyambizi* (a submarine), in that it is capable of hiding itself underwater before surfacing unexpectedly, much like the nature of this viral infection that can exist long before symptoms appear. HIV/AIDS has also been called *mdudu* (literally “the germ”). The *mdudu* is characterized as a destroyer for its devastating effects on one’s life. Some ethnic groups, such as the Haya in Kagera Region, have used a similar characterization, calling HIV/AIDS *ekiuka* (“pest”.) *Ekiuka* refers to nematodes and weevils, destroyers of young banana plants that are a popular staple food among the Haya people (Kamanzi, 2008). *Ekiuka* also refers to how HIV/AIDS affects young people, like the young banana plants infested by pests. Recently people have used terms such as *damu chafu* (dirty blood; contaminated blood; adulterated blood), or blood that is not safe for transfusions. These biological descriptions of the disease illustrate the way in which social and biological factors intermingle. Life is threatened not only through human suffering, but also through plant suffering. Kamanzi (2008) explains the labeling of the disease as the psychological stress in communities. I also argue that different labels of the disease are meant to construct meaning as a way to respond to the confusion behind the virus and the complexity of the disease itself, for which a cure is yet to be found.

Names for the disease continue to change, and physical bodies are often used to describe conditions. HIV/AIDS is now commonly called *miwaya* (cables that transmit electrical energy). The name is based on the idea that one becomes “electrified”

(infected) after touching materials that are not insulated; in other words, one is more likely to be infected if one ignores warnings against unprotected sex. Such language suggests that people are aware of the extent and nature of the disease (Allen and Heald, 2004; Schoepf, 2001).

Miwaya also describes the way in which people are connected and hooked into networks and paths of interaction and infections. Again, the use of the term *miwaya* is an indication that HIV/AIDS will circulate wherever there are connections. Areas that are vibrant are more likely to have more inter-personal interactions, thus creating conditions for the transmission of the virus. The imagery can be interpreted more directly; places that have electricity tend to be active. This electrified environment allows for different activities to take place for extended periods of time in various places, such as bars and clubs. Such environments are assumed to encourage a greater number of sexual interactions. The metaphor can also be extended to include interactions in which a man pays the fees for a woman's connectivity via electronic communication devices, such as mobile phones, in exchange for sex. One wonders if *miwaya* has become divorced from its etymology, and thus has lost some of its inherent potency. Others have termed HIV/AIDS *ugonjwa wa kisasa* (the disease of the modern society), suggesting that this is a modern illness that happens in modern societies, with their intensified human interactions.

The calling of HIV/AIDS *miwaya* and *ugonjwa wa kisasa* combines discourses of networking in modern societies that is widely manifested by the communication revolutions of the 21st century. I argue that technology has played a vital role in addressing global health challenges; however, technology also has escalated the spread of

diseases. Even so, the technology revolution remains the hope of the international community to find ways to address the health challenges of the 21st century. Historically, new technologies have eradicated diseases that posed threats in the world. Technology has enabled people to live longer, even those infected with HIV/AIDS. Despite all these benefits, technology in the globalized world has had adverse effects on the effort to control HIV/AIDS.

Globalization is linked to the spread of HIV/AIDS as well as new infectious diseases and pathogens that are deadly and hard to treat, including Ebola, bird flu (avian influenza), and SARS (Altman 1999). The rapid spread of germs can be said to be caused by networks that have been established throughout the world. Globalization and innovative technologies in a globalized world are also linked to the gross movement of people as well as novel social conditions. These are considered factors in the transmission of HIV/AIDS in both rural and urban areas. For instance, social and sexual relationships, to a large extent, have been enhanced by revolutions in communication technology. Mobile phones appear to be a necessity in modern Tanzania, but they trap people, intensifying sexual relationships, as people with poor economies strive to maintain them and rich people continue expanding their horizons of relationships. Possession of mobile phones has simplified interactions between males and females. It has also enhanced the possible routes for HIV/AIDS transmission.

Yet, despite all the socially constructed meanings and warnings, AIDS prevention initiatives have not resulted in significant declines in new infections (Steinbrook, 2006; Farmer et al., 2001). Different factors have been attributed to the high prevalence rates in some societies. For instance, the secrecy and concealment of HIV/AIDS persist in

societies. At family and community levels, the issue of HIV/AIDS has been met with silence, omission, denial, and the twisting of realities and facts. Family members are less likely to reveal illnesses or deaths that are associated with HIV/AIDS. During funeral ceremonies, people reading eulogies will try to obfuscate, saying that the death was due to short or long illnesses, such as a heart attack, high blood pressure, and diabetes (Nzioka 2000). HIV/AIDS related stigma and stereotype challenges effort to curb the disease, and is considered one of the reasons that people are reluctant to undergo testing consequently many people die before knowing they are infected (Bond et al, 2002).

The former Tanzanian President, Benjami Mkapu, thought that the fight against HIV/AIDS required transformative education and awareness campaigns. When addressing the Second Annual Center for AIDS Research (CFAR) Retreat on September 12, 2006, Mkapu said:

The biggest challenge we face is to wake up to the reality of the economic threat this pandemic is causing to our country, and then to deliberately decide that we will spread the word that the infection can be contained and the diseases can be prevented...Because our society is not open to talking or speaking about people with HIV/AIDS, people are secretive about being infected. They will be late getting tested, and if they learn that they are infected they will not communicate it even to their own families.²⁴³

Since HIV/AIDS progresses through many phases, from infection to full-blown AIDS, people may determine how and when they choose to conceal or reveal their condition. HIV/AIDS often reaches a point at which symptoms are conspicuous, overruling any urge to conceal one's illness. However, in such a situation people often

²⁴³ Source Tanzania Needs Greater Awareness of HIV/AIDS Threat in Archives of September 25, 2006 Volumen 15 No. 18 retrieved from <http://www.inside.duke.edu/article.php?IssueID=155&ParentID=14406&img=1> accessed on April 1, 2011

twist the facts of their conditions, suggesting that it is not HIV/AIDS, but rather bewitchment or another chronic disease, based on the dominant symptoms. Healers noted that people suffering from HIV/AIDS tend to raise complaints of *kulogwa* (bewitchment) and having *mapepo* (bad spells).²⁴⁴

The notion of concealing the status of HIV/AIDS is about power and the lack of it. Infected individuals prefer to conceal their HIV/AIDS status in order to maintain their power in society. Those who are infected or show symptoms of AIDS are eventually assumed to have immune systems too weak to fight diseases, and are thus incapable of demonstrating other forms of power such as parenthood and leadership. Accepting the infection is to relinquish these powers; knowing one's HIV/AIDS status is an embarrassment and humiliation.

The magnitude of the problem is also changing clothing culture. Infected people opt for dresses that cover their entire bodies to mask the associated HIV/AIDS symptoms such as rashes and emaciated bodies. A medical practitioner I met in Mwanza who is working with the HIV/AIDS antiretroviral program in Dar es Salaam noted a trend among people visiting the clinic for ARV drugs. These people wear the *baibui*, a long black outer gown worn over women's clothing that conceals most of the body. This is the dress traditionally worn by religious Muslim women, also known as an *abaya*.²⁴⁵ These women are not all Muslim, but it is an indication of the way in which the epidemic is defining social conditions. The knowledge of HIV/AIDS infection is confined to the group of medical practitioners who interact with people who are infected.

²⁴⁴ Interview, Mdaha Hamo, Butimba-Mwanza February 10, 2010.

²⁴⁵ Interview, Kayaka Kachema, Kirumba-Mwanza, June 15, 2010

TRADITIONAL MEDICINE AND HIV/AIDS IN MWANZA

The HIV/AIDS epidemic is reframing the understanding of medical practices. Use of formal, Western medicine alone cannot overcome this epidemic. Approaches utilizing traditional medicine, which rely on cultural sensitivities and social networks, are critical in developing countries. National and international interventions addressing HIV/AIDS are insufficient because the magnitude of the disease affects populations that cannot fully utilize services offered. Local conditions have been neglected. The proposed interventions do not take into account “accompaniment,” or the continual monitoring of the sick. Western interventions neglect social network support mechanisms to facilitate patient care (Farmer, 1999; Farmer et al, 2006; Kim and Ammann, 2004). The incorporation of traditional healing practitioners and institutions into social treatment programs now appears to be a viable and urgent step to assist in efforts to combat HIV/AIDS (Campbell and Mzaidume, 2002). Traditional healers are especially important responders to this epidemic. Because of their cultural proximity and sensitivity to clients, they can facilitate communication about HIV/AIDS, other diseases, and related social issues.

The persistence of widespread chronic illness, especially one with the magnitude of HIV/AIDS, has fostered the simultaneous use of biomedical and traditional remedies, particularly in Sub-Saharan Africa. Jones (2006) suggests that “Traditional African Medicine” is now applied and fused with other medical practices in home remedies and treatment regimes. HIV/AIDS has redefined the medical landscape and has proven fertile ground for the reconfiguration of more socially embedded biomedical interventions, even

as it has encouraged more entrepreneurial product-based remedies (rather than socio-physical processes and cause-based interventions). Kim and Farmer (2006) suggest that dealing with HIV/AIDS requires an integrative approach that involves availability and access to drugs, as well as continued care for the infected and for caregivers. This approach is essential to reduce the cost of the drugs while strengthening health care systems.

Since independence, the government of Tanzania has strived to ensure equality in Western-style health care services by making them accessible and affordable to the majority of the population. Part of this Western care is a reliance on national disease statistics, including those related to HIV/AIDS, gathered from registered cases from conventional medical facilities. However, many patients with HIV/AIDS seek medical and health care advice and service from traditional healers (Kimati, 2004), due to their comparative abundance in relation to doctors of Western medicine.

Traditional healers do not submit patient information to the national register. Since there are people who go to traditional healers, but not to hospitals, this knowledge suggests that the epidemic is broader than the contours of current data collection. This greater-than-reported magnitude and spread of HIV is undoubtedly reshaping the dynamics of medical beliefs and practices, as many people consult both biomedical and traditional healing practitioners for a remedy.

DRIVERS FOR SEEKING TRADITIONAL THERAPIES

People delay seeking medical treatment when they suspect that they are infected with HIV/AIDS when they are also aware that it is an incurable disease. Respondents in

Mwanza noted that it is common now for the seekers of medical services to be stereotyped as being infected with HIV, particularly for those with persistent and chronic illnesses. Personal stories of individuals visiting medical care units reveal how various symptoms are equated or judged to be associated with HIV/AIDS. Patients feel stereotyped and discriminated against, and some of them decide to consult traditional healers who are seen to be more cooperative and less judgmental. There is a constant tension surrounding the issue of HIV/AIDS. This tension extends to biomedical practitioners and to the approaches they take with patients.

Relatives (sister and brother-in-law) accompanied a patient who had traveled from the Kigoma Region to Mwanza City for treatment. These relatives are what Janzen (1978) calls a “therapeutic management group” (usually family members or relatives who know the condition of the patient and act as decision makers concerning therapeutic choices). They related the situation they encountered in one of the private hospitals in Mwanza. The patient did not receive immediate help, mainly because doctors suspected that he was suffering from HIV/AIDS. The patient had difficulties with urination. He experienced body stiffening and was often unconscious and unable to speak. His relatives took him to a popular private hospital in Mwanza, hoping he would be admitted quickly because they could pay for hospital services. The patient was assigned a bed and doctors came to see him. Since the patient was unable to speak, doctors directed their questions to the sister and brother-in-law. Doctors asked if the relatives knew if the patient was infected with HIV/AIDS, whether he had been tested for HIV/AIDS, or whether the conditions were a side effect of drugs aimed at treating conditions associated with HIV/AIDS. The therapeutic management group did not have answers to those questions.

Finally, the medical doctors, after consultations with other medical personnel at the hospital, indicated that the patient had to be referred to Bugando Referral Hospital, one of the few referral hospitals in Tanzania, about two km from Mwanza City Center. The patient was transferred to Bugando Hospital where he was diagnosed with cerebral malaria, a urinary tract infection (UTI), and a tumor in his bladder that required minor surgery. The patient was admitted to the hospital for a week; the test for HIV/AIDS was negative.²⁴⁶ The patient fully recovered.

Another story captured during fieldwork reveals the tensions and frustrations between medical professionals and patients, particularly related to chronic conditions. A patient who had recovered from tuberculosis (TB) explained that the treatment she initially received at a hospital caused her to give up and seek services from traditional healers. She then sought biomedical services again and she discovered that she had TB but was not infected with HIV/AIDS. She explained:

I was scared to death, the way in which my body was emaciated. I had no appetite; I had sores in my mouth; and I felt severe pains when eating. I regularly visited the local hospital for medical care. I was first diagnosed and treated for malaria and typhoid. But symptoms persisted. After several visits to the hospital, I was personally worried and confused. What was the disease that was troubling me? I had tried different medications for more than six months, and yet I was still in pain and ill. I started worrying that maybe it was HIV/AIDS, even though I was not tested for HIV. I was concerned of my two children thinking the worst-case scenario that if it was HIV/AIDS I will die and leave behind my children.²⁴⁷

She continued by describing her interaction with medical professionals:

The misery was compounded by the statements of the doctor I trusted and the one who attended me regularly. After numerous visits at the hospital; he gave up on me and one day he posed a question to me, ‘Why it is taking such a long time for

²⁴⁶ Interview, Salnani Niliga, Kirumba Mwanza, October 20, 2009.

²⁴⁷ Dahila Lamwena, Butimba –Mwanza, February 15, 2010

you to recover?' He was just tired of my regular visits and he just wanted me to get out of his office. He just prescribed me with painkillers, because other medicines were not effective in his belief that I was suffering from the incurable disease HIV/AIDS, and it did make sense to continue taking drugs. I was discouraged and felt my life was completely gone. I lost hope and I felt there was no need for me to go to any other hospital.”

She further explained her relatives’ understanding as well as her own opinion:

My relatives were worried of my condition that was deteriorating daily; they were also challenged by the question of whether I was infected with HIV/AIDS based on the symptoms. I had persistent coughing, body emaciation, and sores in my mouth the typical symptoms that could be found on people with HIV/AIDS infections. Some family members suggested that I should contact other traditional healers; others persisted that I should try contacting other biomedical doctors in other hospitals.

I mentioned that I have been to the hospital many times and I should try seeking services from traditional healers. I was attended by various healers without any improvement and again my relatives decided I should go back to the hospital where tests showed that I was not infected with HIV/AIDS, rather I had tuberculosis that had reached a critical stage, because of delayed treatment. I was given medication for about six months and my conditions significantly started improving after the first week of medication.

The above case is indicative of the fear and uncertainty surrounding HIV/AIDS patients seeking medical care. The HIV/AIDS epidemic manifests itself through fear, worry, secrecy, and a loss of confidence among individuals in society. Healers noted that some clients resist and refuse medical tests. Clients tell healers that it is not a healer’s duty to make decisions about what a client must do. One of the healers interviewed explained his experience:

I receive patients whom I suspect to have been infected with HIV/AIDS. They fight or argue when I advise them to undergo medical tests; they accuse me that I am suggesting to them that they are infected. However, those who follow my advice see the benefits by the counseling services they get.²⁴⁸

²⁴⁸ Interview, Mdaha Hamo, Butimba-Mwanza, February 10, 2010.

Fear of an HIV diagnosis produced different kinds of decisions about medical services. People who are sick are afraid to go to biomedical units because of a) the inadequacy of medical doctors and the possibility of being treated for the wrong conditions; b) the inadequacy of traditional healers' ability to treat something like TB (an easy treatment); c) the fear of being stigmatized by HIV/AIDS (whether they have it or not); and, d) the fear of being diagnosed with HIV/AIDS (if they have not already been).

Health care givers in biomedical units are confused by the symptoms of their patients. Furthermore, patients are often frustrated by responses they receive from medical doctors and consult traditional healers even for conditions, such as TB, that can effectively be treated by Western medicine. This situation was observed in a Misungwi district hospital where a patient who received antiretroviral drugs explained the choices of therapies for the condition associated with TB:

I was tested following the dry cough I was experiencing regularly. Initially, I used Sukuma traditional medicine and did not see any improvement. However, there was a time when the coughing reduced, but it reoccurred with other symptoms including abdominal pain and coughing. I was tested and diagnosed with TB and HIV²⁴⁹

These stories demonstrate how the possibility of HIV/AIDS reframes the way biomedical practitioners approach symptoms of a patient. Most immediately suspect HIV/AIDS as the cause of symptoms and thus treat the patient and their care differently. The patients were subject to differential access to medical care due to over-diagnoses of HIV/AIDS. Patients and their relatives were dissatisfied with their treatment at hospitals

²⁴⁹ Interview, Salame Lame, Misungwi Hospital, June 22, 2010

when dealing with HIV/AIDS symptoms. The confusion between doctors and patients delayed and restricted attention, provided incorrect prescriptions, and caused patients to seek alternative care.

Bayer and Oppenheimer (2000) reveal that AIDS permeates public consciousness and thus shapes meaning for different groups of people—like doctors and patients. The complexity of the disease is matched by complex interventions. This complexity often results in limited options to respond to the disease. In Mwanza, the disease threatens the lives of many people and is regularly discussed among different groups. One of the groups that has been directly or indirectly involved in the discussion and provision of health care for people through time has been traditional healers, who now also offer services to those suffering from HIV/AIDS.

HIV/AIDS AND GEO-SPATIAL ARRANGEMENT OF TRADITIONAL HEALERS

Since the colonial period, traditional healers have settled in new regions as a consequence of environmental changes caused by human activity and climate change, including government policies (forced migrations, e.g., Ujamaa, see chapter 3), economic conditions (the need for livelihood), epidemiological changes (the need for health services), and access to biomedical (Western) services. Such changes have influenced migration patterns and transformed medical practices among traditional healers in the Mwanza Region. Among the Maasai in Tanzania, their rural-to-urban migration is driven largely by poverty, hunger and drought (May and McCabe 2004). Such economically-driven migration changes societal dynamics and defines different forms or divisions of labor (Nelms and Gorski, 2006). Many Maasai traditional healers (originally from the

Arusha Region in Northern Tanzania) have reacted to market forces by becoming traditional-medicine entrepreneurs. A 1998 study of Maasai herbalists showed that the majority of women engaged in the traditional healing business are doing so because of poverty rather than apprenticeship (Ibrahim and Ibrahim, 1998).

My observations in Mwanza suggest that when healers, who traditionally live in rural areas, migrate to urban areas, their practices are converted from health-oriented medical practices to commodity-based businesses. This change results in a loss of strong social networks between patients and healers. The commoditization of traditional medicine challenges Leonard's (1998) argument that traditional healers are primarily motivated by health outcomes. The migration to and occupation of new places by different groups of healers gives rise to both opportunities and conflicts. Such movement allows for flows of medical knowledge among healers and offers choices for consumers of medical therapies.

On the other hand, human mobility is also "a key neglected factor in explaining the transmission of diseases such as HIV/AIDS" (May, 2003). Traditional healer migrations, like the migration of other members of the community, can lead to conflicts with already established, long term residents over land ownership and use. Furthermore, healers have to adapt to new cultures, languages and descriptions of medical conditions when they migrate to new places and, inevitably, when competition for patients arises.

The devastating effects of HIV/AIDS have helped catalyze the use of traditional medicines and natural products as well as the consultation of people offering alternative health care services. HIV/AIDS has caused the increased demand and consumption of traditional medicines and has also determined where healers operate. Studies reveal the

relationship between human mobility, as created by increased roads or commerce (fishing, mining), and risks of increased HIV/AIDS infections (Parker, Easton et al. 2000; Lydié, Robinson et al. 2004). Other studies show how HIV/AIDS influences migration from urban areas to rural areas. Those who are sick seek support systems from their relatives in their home village (Ssengozi, 2007). These studies rarely show the ways in which traditional healers' mobility is influenced by infected clients or their relatives. My fieldwork demonstrates that HIV/AIDS is driving geospatial arrangements of healers in societies. Some of the interviewed healers noted that they have migrated to new places after being invited by clients in need of HIV/AIDS therapies.

A healer from Sumbawanga, in the Rukwa Region (in the central part of Tanzania, about 900 kilometers south of Mwanza), moved his services to Mwanza and settled in the nearby area of Butimba. He left Sumbawanga in 1990 by invitation of a Harbor official in Mwanza whose relative suffered from HIV/AIDS. The healer became popular after the relative gained some relief for HIV/AIDS symptoms. Many patients sought out this healer's care, some coming from as far as Uganda. At the time of my visit the healer noted that about ten Ugandans were visiting him to collect therapies aimed at HIV/AIDS. The healer explained that his medicine was capable of increasing CD-4 (the cell responsible for fighting infections but prone to attack by HIV), and could treat opportunistic infections associated with HIV/AIDS (e.g., fever, skin conditions, stomach, and headaches). His previous clients had referred the new patients to him.²⁵⁰

²⁵⁰ Interview Isaka Kale, Butimba Mwanza, February 10, 2010

One conspicuous feature in Mwanza is the increased commercialization of healing practices. Services from healers respond to a wide array of conditions associated with HIV/AIDS (Figure 20). Another healer from Kagera, Teluga Lumbwa, explained how he had opened an office in Mwanza. Lumbwa opened the unit in 2008 after an employee at an international agency in Mwanza brought a patient to the healer's house. The patient had symptoms of HIV/AIDS and Lumbwa offered therapies that seemed to improve the patient's condition. Since the therapy was successful, the person who brought the ill client became Lumbwa's sponsor, paying TSH 1,800,000 (roughly US \$1200) for the first year's rent



Figure 20: Advertising traditional medicine in Mwanza

on an office in Mwanza City and for the purchase of a locker to store medicine.²⁵¹

The existing conflicts between biomedicine and traditional medicines are also the result of competition for economic opportunities. Current trends suggest that healers are creatively adapting to a landscape that includes biomedicine, including borrowing competitive strategies to “sell” traditional medicine. Fieldwork in Mwanza indicates that healers have adopted practices that mimic biomedical ones, such as prescriptions, medical fees, and the packaging of medicine. Commoditization of health and health care through the buying and selling of medicines has given rise to some lively debates (Van Geest et al. 1996) in medical anthropology, especially when people see health as

²⁵¹ Interview, Teluga Lumbwa, Mwanza City, February 24, 2010.

something one can obtain through the consumption of pharmaceuticals. Van Geest et al. refers to this trend as “defective modernization,” asserting that it impoverishes the concept of health and gives people a “false sense of health security.”

HEALERS’ SOCIAL CONSTRUCTION OF HIV/AIDS IN MWANZA

Healers, in general, are confused by the nature of HIV/AIDS. Familiar symptoms often do not respond to known treatments, transmission does not always follow rational patterns, and infected patients often act contrary to rational responses related to the disease. Due to the nature of HIV/AIDS, remedies often do not work without stronger medicines. Kabhula Stefano, a female healer, revealed her confusion about the behavior of HIV/AIDS:

If you examine closely it is hard to understand what is going on, you wonder why diseases like this were not there in the past. I have seen many who are sick in this village. There was one person who was infected; he has two wives, but when tested, one of them was not infected; I did not understand how it was possible she was not infected though the other wife tested positive. The wife who tested positive decided not to tell her husband. However, one day her husband discovered the hidden medical record of the infected wife, but [could do] nothing, because he was also infected.²⁵²

It is common to confuse HIV/AIDS symptoms with those of other diseases. As one healer respondent noted, he cannot detect HIV/AIDS symptoms just by observation; different diseases can have similar symptoms.²⁵³ Healers also noted they have to take necessary precautions whenever they receive patients in order to avoid further infections in their units.²⁵⁴ Some healers compared HIV/AIDS to a disease famously known as *safura*,

²⁵² Interview, Kabu Seno, Sanungu-Lugeye, August 7, 2009

²⁵³ Interview, Mdaha Hamo, Butimba-Mwanza February 10, 2010

²⁵⁴ *ibid*

which results in body emaciation or body swelling. “The majority of patients are troubled by *safura*. There are two kinds of *safura*, namely *safura ngosha* (characterized by wasting) and *safura nkema* (characterized body swelling).”²⁵⁵ One of the interviewed healers noted that he advises clients with such conditions to undergo medical testing at the hospital, telling them that the biomedical professionals will advise them accordingly on whether the disease can be treated in the village (using traditional medicine), or if the disease can be cured at the hospital.²⁵⁶ Another healer showed a different approach in dealing with patients with *safura* noting, “When treating such conditions, clients are advised not to receive medication in the form of injections at the hospital.” He noted, “Giving traditional medicine to the person who is injected risks their life.”²⁵⁷ Confusion about the disease among traditional healers is shown in these contradictory diagnostic and curative measures.

Other respondents were confused by the effectiveness of the therapies available for HIV/AIDS. One of them noted that she has heard about the availability of the ARV medicines and still received patients with symptoms that she feels are HIV/AIDS, noting:

They have announced that the treatment for HIV/AIDS has been obtained, but still there are people coming here having sores from their mouths to their anuses and they have serious diarrhea. But if you give them medicine they get relief like what is happening in medical hospitals.²⁵⁸

Confusion about the disease is also reported in other countries. A study conducted in Ethiopia, for instance, suggested that women in rural regions refused to believe

²⁵⁵ Interview Healers Hera Radani, Mbarika-Misungwi, April 14, 2010 and Kakolo Nanga, Nyasato-Lugeye, July 23, 2010

²⁵⁶ Interview, Hera Radani, Mbarika, Misungwi, April 14, 2010

²⁵⁷ Interview, Kakolo Nanga, Nyasato-Lugeye, July 23, 2010

²⁵⁸ Interview, Sangela Ng’wela, Ndagalu Magu, August 8, 2009).

HIV/AIDS was a health problem. If it were, they considered the disease to be a disgrace brought to them by men in the village (Nelms and Gorski, 2006). In explaining the rationale of the epidemic in modern times and why the disease has no cure, one of the interviewed healers noted:

God has brought this calamity, because of our misdeeds. See how boys and girls disobey their parents; it was not like that in the past. There were rules in the past; girls were restricted coming home later than 6 pm. Similarly, young boys were restricted from sleeping away from their homes. Everybody at home adhered to the traditions, but these *maadili* (ethics/morals) have disappeared, because of modernity. During the era of our grandparents, big diseases were *bunyoro* (gonorrhoea), *kaswende* (syphilis), and *kabambalu* (lymphogranuloma inguinale). All these diseases were easily treated. But we have angered God; he has abandoned us to suffering and feeling the pain from our misdeeds. In the past if a person dies in the village, people in the entire village will grieve and participate in a mourning ceremony, but now people bury the deceased ones without sympathy. In the past people showed their sorrow by suspending activities such as going to the farm until the deceased is buried.²⁵⁹

As shown in chapter one, the Mwanza Region now hosts several different groups of traditional healers, including herbalists, diviners, and spiritual healers. Three different groups of clients consult these various healers: those who visit traditional healers as their primary health provider, those who have first visited biomedical facilities for treatment, and those who alternate between biomedicine and traditional medicine. The silent and secret nature of HIV/AIDS suggests that people who think they have or know they have HIV/AIDS often consult traditional healers for confidentiality reasons. Clients assume that the traditional healing therapies are effective; they also think healers respect confidentiality. Most traditional healers are trusted members of the community. In

²⁵⁹ Interview Busole Mobi, Bujora-Mwanza, September 3, 2009.

addition, they do not keep medical records and do not have scientific proof to confirm whether or not clients are actually infected with HIV/AIDS.

A fourth group of patients also exists. This group includes people who have consulted traditional healers after having been medically diagnosed with the HIV/AIDS virus. These people previously tried Western medicine without success and assume that traditional healing therapies can provide effective treatment for HIV/AIDS. The expectation of people in this group runs contrary to therapies traditional healers can offer. These patients are seeking a cure and HIV/AIDS has none. Treatments consist only of life-prolonging drugs, treatment of opportunistic infection, and revitalization of people's ability to resume normal work. It is worth noting here that most traditional healers with whom I worked did not claim any ability to "cure" HIV.

Increasingly, many healers now market immune-boosting supplements. This is true for native healers and for newer arrivals. Maasai healers who migrated to the Mwanza area operate ubiquitous roadside stands for the sale of their remedies. Many, however, complained bitterly about being reduced to such commercial practices, particularly when asked to refer patients to medical units for conditions such as tuberculosis and HIV/AIDS.

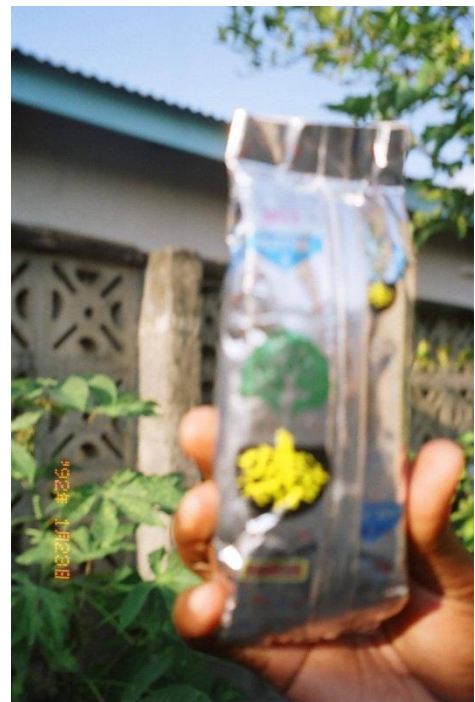


Figure 21: A package of Ngetwa herbs advertised to treat many conditions

As demonstrated above, traditional healers have adapted to biomedical concepts of HIV/AIDS by using traditional therapies to treat

opportunistic infections. These treatments allow people to resume their livelihoods. One of the conspicuous features among healers is that their therapies could treat many conditions or multiple illnesses resulting from HIV/AIDS. Healers are aware that selling medicine in a contemporary setting requires understanding the complexity of the health challenges of the 21st century. Some diseases are difficult to treat; others require combined therapies. Using a global understanding and discourse concerning the HIV/AIDS problem, healers responded by showcasing medicines advertised to invigorate the immune system, treat opportunistic infections, and provide energy to the infected. Some of the remedies consumed in East and Central Africa, but produced in Tanzania, were *ngoka 11* and *ngetwa* (Figure 21). Both of these are popular, traditional medicines derived from local herbs. These remedies were advertised in the 1990s for multiple conditions, including opportunistic infections (Hsu 2002; Schumaker and Bond 2008).

The idea of offering such medicinal products for HIV/AIDS treatment was a result of the realization that HIV/AIDS is an incurable disease that is associated with multiple symptoms that cannot be addressed by a single drug or remedy. My experience in the region indicated that it is now common language for healers to suggest that the medicines they are administering to people are a combination of different herbs used to respond to multiple and chronic conditions. The manifestation and persistence of HIV/AIDS in societies has allowed traditional healers to make meaning and characterize causes, symptoms, impacts and solutions in many different ways. The characterization of causes, for instance, follows the same patterns whether the disease is natural, manmade, or a violation of ancestral directives. Many traditional healers acknowledge that HIV/AIDS is a serious problem and that no single intervention strategy has proved

efficient in dealing with the epidemic. They noted that dealing with HIV/AIDS requires effort from every individual. Sukuma healers compare HIV/AIDS to diseases observed in the past, such as *kondela* (a mix of sexually transmitted diseases), *kanjanja* (sexual transmitted disease), and *bunyoro wa mpaga uche* (incurable gonorrhea ending in death). One Maasai healer operating in Mwanza shared the view of Sukuma healers, suggesting that similar diseases existed in the past:

There was AIDS in the past; there were people with emaciated bodies like those who are suffering from HIV/AIDS now. In Arusha, that disease was called *emoyanado*, and the person was very thin, and the disease was chronic staying for a long time. The *emoyanado* disease is still there.²⁶⁰

The Maasai healer operating in Mwanza City showed how the preventive measures in HIV/AIDS has had positive effects for other health conditions that were common in the past:

The sexual transmitted diseases have decreased nowadays, and this is mainly due to the use of condoms to protect against HIV. In the late 1990s and early 2000s, I was able to receive three patients on average each day with STDs, but nowadays a month could pass without seeing any patient seeking therapies for STDs.²⁶¹

HEALERS' DIAGNOSES AND CHARACTERIZATION OF HIV/AIDS SYMPTOMS

Over the years, healers have been challenged regarding their inability to diagnose HIV/AIDS because of lacking scientific equipments. However, healers are the one of the immediate groups that people contact if they suffer from or suspect they are infected with HIV/AIDS. Healers have gained a substantial knowledge base about symptoms linked to

²⁶⁰ Interview, Oleluca Laze, Mwanza City February 12, 2010

²⁶¹ Interview, Oleluca Laze, Mwanza City February 12, 2010

HIV/AIDS through their continued interactions with people dealing with the various manifestations of this complex of diseases.

Many healers characterize HIV as a sexually transmitted disease and acknowledge they do not have an effective cure for the epidemic. More often, healers treat opportunistic infections (fungal, bacterial, protozoan, and viral diseases that affect people with weakened immune systems) when encountering people suffering from HIV/AIDS. One healer in Mwanza recalled, “I did receive two male patients of HIV/AIDS and what I could offer are therapies to stop diarrhea, and to treat sores in genital areas.”²⁶²

In my discussions with different groups of healers, I recorded numerous symptoms associated with HIV/AIDS infections including regular fever, headache, pains in joints, loss of appetite or increased appetite, thinning and losing hair, persistent diarrhea, *utando mdomoni* (oral thrush), body emaciation, rashes, sores, *kichomi* (sharp pain sometimes accompanied by pneumonia), body swelling, *utapiamlo* (symptoms of malnutrition), body weakness, persistent cough, regular fever, dry skin, and soft-white gums due to anemia.²⁶³ Healers’ characterizations of HIV/AIDS correlate with symptoms recorded from patients enrolled in antiretroviral drug treatments at Misungwi District Hospital in Mwanza. A male HIV/AIDS patient in his early thirties, whose father passed away from HIV/AIDS, related his experience caring for his ill parent and himself:

My dad had a persistent cough and was diagnosed with TB since 2008. I took care of my dad when he was ill. My father felt pain when urinating and his body was itching. I was very close to my father, but he was late using antiretroviral drugs. He used them for seven months before passing away. He was troubled

²⁶² Interview, Mama Eza, Mwanza City, July 7, 2009.

²⁶³ Mdaha Hamo, Butimba-Mwanza February 10, 2010; Mama Eza Mwanza city, July 7, 2009 ; Isaka Kale, Butimba Mwanza, February 10, 2010; Robe Chani., Matala-Busunguku, Mbarika, Misungwi; March 16, 2010; Thoma Mande, Seke Misungwi, October 8, 2009

with *miguu* (pains in his legs), *kichomi* (sharp pain in his chest more like pneumonia) and *kichwa kilikuwa kinamuuma* (headaches) and *homa haziishi* (regular fevers).²⁶⁴

Another notable condition described by healers was issues with urination. One of them noted that HIV/AIDS is often accompanied by *lusubalila* (failure to control urination), because HIV/AIDS may trigger the occurrence of urinary tract diseases that lead to bladder control failure.²⁶⁵ Despite a lack of diagnostic equipment, healers have devised methods to identify problems associated with HIV/AIDS. When asked how he differentiates people infected with HIV/AIDS from other conditions, one healer noted that he “will observe their physiological condition and listen to their complaints. In most cases, people infected with HIV/AIDS will have soft hair that is falling out, excessive appetite for food, *mang’hondi* (hemorrhoids), and infections on the skin that do not respond to medications. Whenever I see clients with these conditions, I advise them that their condition requires medical tests.”²⁶⁶

Another healer had a different approach, noting, “You will know something is wrong from the breath of the person who is sick; their stool has a lot of gases; their urine is also not clear; they are mentally disturbed”²⁶⁷ A third healer identified people suffering from HIV/AIDS by asking them to open their mouths to observe if they have oral thrush. “I also observe the skin of my clients. People infected with HIV/AIDS tend to have *ngozi iliyokakamaa* (dry skin). I advise these patients that, in order for me to treat them, they

²⁶⁴ Interview, Salame Lame, Misungwi Hospital, from Igokelo. June 22, 2010

²⁶⁵ Interview, Hera Radani, Bugwisha-Mbarika, Misungwi, April 14, 2010

²⁶⁶ Interview, Jomayo Mayoma, Matara village, Sumbugu-Mbarika, Misungwi, and March 20, 2010

²⁶⁷ Interview, Hera Radani, Bugwisha-Mbarika, Misungwi, April 14, 2010

must first undergo medical tests for HIV/AIDS. I tell them that there are good medicines in hospitals for people diagnosed with HIV/AIDS. I used to counsel them that they should have *matumaini* (hope), despite being infected with HIV.”²⁶⁸ One of the interviewed traditional healers asked his clients for their medical reports showing levels of CD-4 in order to determine if there is any improvement with his therapies. He asks his clients to have regular tests to determine if CD-4 cells are increasing because CD-4 cells counts are an important indicator to measure the progression of the disease.²⁶⁹

Identifying symptoms of HIV/AIDS without the use of biomedical technologies and metrics has an impact on the treatment offered by traditional healers. A major difference between traditional healers and biomedical professionals is the timing of observations of HIV/AIDS symptoms. Biomedical professionals often observe symptoms earlier in HIV/AIDS patients because of access to technology for those who visit biomedical facilities. Biomedical professionals have the capacity to observe the progression of the disease, from the time of infection to full-blown AIDS, by using the World Health Organization’s pediatric clinical staging of HIV/AIDS (see Table x) and the Disease Staging System for HIV Infection and Disease (Morgan, Mahe et al. 2002). Those who seek treatment from traditional healers, as explained above, often seek treatment well after the symptoms of HIV/AIDS have progressed. My findings indicate that symptoms traditional healers observe often fall under stage three and four of the

²⁶⁸ Interview, Teluga Lumbwa, Mwanza City. February 24, 2010

²⁶⁹ Interview, Teluga Lumbwa, Mwanza City. February 24, 2010

WHO staging system of HIV/AIDS (Table 1), demonstrating a lag response when compared to patients observed in Western biomedical programs.

PROPOSED WHO STAGING SYSTEM FOR PATIENTS INFECTED WITH HIV_1	
<p>Stage 1:</p> <ul style="list-style-type: none"> · Asymptomatic · Persistent generalized lymphadenopathy <p>Stage 2:</p> <ul style="list-style-type: none"> · Weight loss between 5% and 10% of body weight · Minor mucocutaneous manifestations (seborrheic dermatitis, prurigo, fungal nail infections, recurrent oral ulcerations, angular stomatitis) · Herpes zoster within the past five years · Recurrent upper respiratory tract infections (for example, bacterial sinusitis) <p>And/or</p> <ul style="list-style-type: none"> · Performance scale 2: symptomatic, normal activity <p>Stage 3:</p> <ul style="list-style-type: none"> · Weight loss > 10% body weight · Unexplained chronic diarrhea for longer than one month · Unexplained prolonged fever (intermittent or constant) for longer than one month · Oral candidiasis · Oral hairy leukoplakia · Pulmonary tuberculosis within last year · Severe bacterial infections (for example, pneumonia, pyomyositis) <p>And/or</p> <ul style="list-style-type: none"> · Performance scale 3: bedridden for less than 50% of the day during the last month 	<p>Clinical stage 4 (AIDS):</p> <ul style="list-style-type: none"> · HIV wasting syndrome* · Pneumocystis carinii pneumonia · Toxoplasmosis of the brain · Cryptosporidiosis with diarrhea for more than one month · <i>Cryptococcus</i>, extrapulmonary · Cytomegalovirus infection of an organ other than liver, spleen, or lymph nodes · Herpes simplex virus infection—mucocutaneous for more than 1 month or visceral of any duration · Progressive multifocal leukoencephalopathy · Any disseminated endemic mycosis · Candidiasis of the esophagus, trachea, bronchi, or lungs · Atypical mycobacteriosis, disseminated · Non-typhoidal salmonella septicemia · Extrapulmonary tuberculosis · Lymphoma · Kaposi's sarcoma · HIV encephalopathy† <p>And/or</p> <ul style="list-style-type: none"> · Performance scale 4: bedridden for more than 50% of the day during last month

Table 1: Symptomatic progression of HIV/AIDS, developed by the World Health Organization, indicates the symptoms that are shown by patients at different stages of the disease. (Adopted from (Morgan, Mahe et al. 2002)

HIV/AIDS presently has no cure. This is widely accepted in both Western medicine and by the general populace; Tanzania is no exception. Despite this fact, two groups have emerged to act contrary to this information. The first consists of con men and quacks who want to secure money illegally by tricking people who are desperate for a cure for HIV/AIDS. Actions from this group affect the trust, legitimacy, and credibility

of healers. Their presence has led some traditional healers to appeal to government enforcement agencies to monitor traditional healers' activities and to take necessary measures against those who violate laws, such as selling false HIV/AIDS cures. The second group includes a peer-group of traditional healers in Mwanza who suggest that they are capable of curing HIV/AIDS and its opportunistic infections. A healer from Nyamanoro, Mwanza explained, "If a patient is brought to my attention at the early stages of the disease, there are possibilities they will be cured."²⁷⁰ Boasting of his ability to treat people infected with HIV, the healer noted that he is now recognized even outside the country and also treats foreigners suffering from HIV/AIDS. He said, "I attended a patient for seventeen days. I have noticed, however, that Arabs have a tendency to conceal problems they have, particularly when they are suffering from HIV/AIDS. But, I had another patient from there (Muscat, Oman), who stayed at my place for three months."²⁷¹ Another respondent noted that HIV/AIDS treatment requires a long duration, from three to four months. Supporting this argument, the respondent added, "Patients diagnosed in 1990 and 1995 have survived and they are healthy."²⁷²

Healers have different opinions about whether HIV infection and prevalence rates are increasing or decreasing. Many traditional healers note that the problem is still big and many people continue to die. A healer practicing medicine in the Misungwi district said, "The disease is escalating. In my opinion, if it was going down, we would have less people admitted in hospitals, and the government would announce that the HIV/AIDS epidemic is controlled. There are many people who are ill and the infections are still

²⁷⁰ Interview, Samsa Kamo, Butimba-Mwanza, February 11, 2010

²⁷¹ Interview, Samsa Kamo, Butimba-Mwanza, February 11, 2010

²⁷² Interview, Isaka Kale, Butimba_Mwanza February 10, 2010

there.”²⁷³ On the other hand, some, but fewer, traditional healers see progress against HIV/AIDS and think that antiretroviral drugs have helped to control the disease.²⁷⁴ These varied explanations show the contours of the disease itself. A healer’s perception, whether the disease is increasing or decreasing, is based upon healers’ observations of clients they receive and information they obtain from media sources.

AWARENESS CAMPAIGNS: FROM INTERNATIONAL TO LOCAL

Although the HIV/AIDS epidemic would feature in all four presidential phases (1983 – 2010) in Tanzania, the magnitude of the problem was not yet realized when Nyerere relinquished power to Mwinyi in 1985. Since then, however, the problem has changed the labor force and the economic conditions of the family unit and the nation as a whole. The devastating impacts of HIV/AIDS began to be recognized in families and in the nation during Mwinyi’s presidency during the late 1980s and early 1990s. The brunt of the impact of the disease hit the poor and no life-prolonging drugs existed at that time. As a result, many citizens died at a very young and productive age. Since its emergence, both biomedical institutions and traditional healers have worked to find a cure while offering necessary support to people infected and affected by HIV/AIDS. Through interaction with patients and other sectors, healers have learned an enormous amount about the epidemic. Healers discuss social life and the ways infections may occur. Likewise, healers have advertised and sensitized the public about conditions responsible

²⁷³ Interview, Hera Radani, Bugwisha-Mbarika, Misungwi, April 14, 2010.

²⁷⁴ Interview. Mabilia Tobi, Nkolati Mbarika, April 15, 2010.

for the HIV/AIDS transmission. Interviewed healers noted that we live a risky world at a precarious time. They have pleaded with people to take precautions against the epidemic.

International and national programs emphasize the preventive approach as an effective measure to control the HIV/AIDS epidemic (Heald 2006). Through awareness campaigns, people are told to abstain from sexual activity, to maintain their relationship with their partners, to use condoms

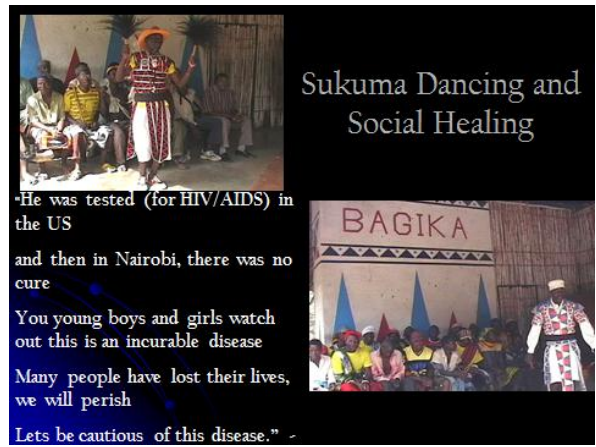


Figure 22: Healers advocate preventive measures to HIV/AIDS epidemic

during sexual encounters; and to seek testing, counseling, and registration for antiretroviral drugs (Allen and Heald 2004). These campaigns are conspicuous in urban areas through media, schools, colleges, hospitals, and non-governmental organizations. Healers' involvements through formal awareness programs remain peripheral and their contributions through informal settings are rarely acknowledged. My research has revealed the remarkable contribution that traditional healers can have on awareness campaigns to reverse the magnitude of HIV/AIDS problems in the Mwanza Region.

The use of traditional healers in campaigns to educate people about HIV/AIDS is a step toward reducing infection rates and also toward encouraging people to undergo voluntary testing and counseling services. These approaches are considered beneficial; they create conditions for people to learn their status and to take necessary protective measures to prevent further spread of the disease. Though not recognized as agents for change in improving health for all, traditional healers have assiduously responded to

HIV/AIDS in their songs and dances. Using songs, healers have raised awareness in society, telling people about the risks, magnitude and nature of the HIV/AIDS epidemic, the impacts on society, the local and international efforts and their successes or failures, and the need for new approaches to effectively respond to the crises.

A well-known traditional healer and song composer in the Mwanza Region demonstrates the devastating effects of HIV/AIDS in one of his songs. He notes that people have turned to prayer in hopes for a solution. In conversations with him, this healer noted that, presently, HIV/AIDS has devastating effects, much like the *tauni* (pestilence) in the past. He recalled that, during the era of his grandparents, *tauni* (pestilence) was a feared disease due to its devastating effects. The HIV/AIDS epidemic has seriously affected *ukanda wa maziwa makuu* (the Great Lakes Region in Africa).²⁷⁵

Another healer, Mzee Nhimbili, a popular *ningi* (song composer) for a Bagalu dancing group in Sukumaland, has also acknowledged the magnitude of the problem. He has used songs to caution people. In one song, Mzee Nhimbili warns the younger generation to be cautious and to protect themselves before succumbing to infection. “You, if you think you’re brave enough to stand against AIDS, know that your days are short. Know, too, you will leave your children behind. Girls and boys, be wary of AIDS, for the nation and the world depend on you.”²⁷⁶

The use of traditional mechanisms of communication from respected leaders, healers and performers, such as dance and song, has had a strong influence on people’s awareness and actions surrounding HIV/AIDS. Healers recognize that HIV/AIDS cannot

²⁷⁵ Interview, Busole Mubi, Kanyerere –Misungwi, September 3, 2009

²⁷⁶ Interview, Nhumbu Bumila, Buhimila, Kisesa Mwanza, July 22, 2007

be dealt with in isolation from other health challenges in the region. They have been at the forefront of efforts to educate the public. One of the interviewed healers noted that, although HIV/AIDS has devastating effects, other diseases have seriously affected communities as well. This healer explains the magnitude of the problem in places he had visited. “Everywhere I go I meet this calamity, places like Bukoba (a city/district/region northwest of Mwanza). The disease has claimed the lives of many people. In countries like Burundi and Uganda people are dying like sardines.” His comparison connects the way in which people lose their lives in large numbers to way in which sardines (*Rastrineobola argentea*) in Lake Victoria are harvested and killed *en masse*. He sees the fate of the disease in God’s hands, noting, “It is only God who can help people; mainly, because it is not only HIV/AIDS, but also other diseases such as *Homa ya Bonde la Ufa* (West Nile Virus), which is also killing many people, I have never seen something like this.”²⁷⁷

The information from healers is also corroborated by the government’s decision to respond to other health challenges apart from HIV/AIDS. The devastating social and epidemiological effects of HIV/AIDS is compounded by the emergence of other diseases such as *mafua ya ndege* (bird flu). The bird flu epidemic forced the Prime Minister to declare a “national disaster,” and forced the Tanzanian government to close some schools in Mwanza as a preventive measure against bird flu in 2009.²⁷⁸

²⁷⁷ Interview, Mubi Makemo, Kanyerere-Misungwi, September 3, 2009.

²⁷⁸ Mwanza region has closed all the primary and secondary schools and restricts all kinds of gathering purposely to prevent the transmittion of Mafua ya Nguruwe. The Regional Commissioner was quoted saying that awareness is needed particularly to the People of Ilula Village in Kwimba district is order to take preventive measures that will prevent spread of the disease. The District Commissioner in Kwimba Christopher Kangoye noted that victims under

HEALERS' ENGAGEMENT: A NEW FRAMEWORK

According to the late Fr. Sandu, of the Bujora Missionary church and the Sukuma Museum, traditional healers have high expectations for their healing activities, but they lack a sense of unity and the financial base to improve their services. Some healers acknowledge these deficiencies and see collaboration as one way to improve their health and medical care delivery opportunities. However, traditional healers of all ethnic groups interviewed in Mwanza lamented that their roles are hardly recognized in preventive and curative measures for HIV/AIDS. A Maasai healer operating in Mwanza noted, “We have not received the support; they were supposed to establish the laboratory and test our medicine. One time they collected our medicine for testing but they never brought back the results even though they took our medicine.”²⁷⁹

In some situations healers felt insecure and were worried about being punished for suggesting that they have knowledge and therapies to cure certain ailments. As one of them noted, “If you are famous or known to treat this condition (HIV/AIDS), it is more likely that you will be arrested by the government.”²⁸⁰ Another healer expressed the same kind of fear:

I dreamed about a therapy that could be used to treat people suffering from HIV/AIDS, but I was worried to tell the government officials. I feared being

quarantine at Ilula primary school had remained with 30 as of November 30. There were about 221 cases of people who were reported suffering from the disease. , others have been discharged (Source: *Nipashe* Desemba 2, 2009 “Wagonjwa saba zaidi mafua ya ndege”)

²⁷⁹ Interview, Oleluca Laze, Mwanza City, February 12, 2010.

²⁸⁰ Interview, Bang'wa Ng'wama, Sanungu-Lugeye, August 7, 2009

arrested and punished. I remember one day [government officials] came to our village in Mawe and threatened healers practicing divination that they will be punished if continue practicing divination.²⁸¹

The above cases show the way in which healers' confidence in their knowledge and therapies is compromised by fear based on past experiences of persecution and arrest. Yet, healers' involvement in HIV/AIDS programs serves different purposes, such as minimizing the risk of infection in their units. Some of the interviewed healers are aware of the risks when dealing with people who are infected. Majukano Tobias noted the risks involved for healers:

Our therapies involve descaling the tongue of the patient in what is called *ukulele* (removing oral thrush). We protect ourselves by wearing gloves given at the hospital. We had received gloves freely from hospitals before our licenses were revoked in early 2009, following accusations that healers were complicit in violence against albinos. We wore them to avoid infections through blood contact.²⁸²

Healers have responded to the HIV/AIDS epidemic and lack of protective equipment and are now using different strategies to protect themselves against infections by encouraging and directing patients to attend to themselves when eating. They also ensure each client uses separate vessels for eating and drinking.²⁸³

Healers are aware of the discrimination against people suspected of having HIV. Healers noted that they do not discriminate against people with HIV/AIDS for two reasons. First, it is hard to know if each client is infected with HIV/AIDS. Second, their professional ethics restrict discrimination for medical or health services, no matter what condition someone may have. James, a Maasai healer, explained, "We healers do not deal

²⁸¹ Interview, Geka Kami, Lugeye-Magu, November 10, 2009

²⁸² Interview, Mabia Tobi, Nkolati Mbarika, April 15, 2010.

²⁸³ Interview, Hera Radani, Bugwisha-Mbarika, Misungwi, April 14, 2010

with just one disease; we treat different diseases. I am always available to treat all patients who come to me, and what is guiding me in offering therapies is my ancestral spirits.”²⁸⁴

The acknowledgement that they lack testing equipment for HIV/AIDS occurred repeatedly in my discussions with healers. They adapt to this situation by referring their clients to biomedical units for testing, particularly when they suspect HIV/AIDS infections. One healer explained:

I advise my clients to be tested first at the hospital before receiving my therapies. I had a female client who was brought by her parent from the hospital. She was tested HIV positive and I also noticed that she had developed some opportunistic infections. Her mother pleaded that I try attending her daughter. I tried and she had temporary relief but she later died, because *Ukimwi ni ugonjwa mzito* (AIDS is a heavy diseases).²⁸⁵

Healers offered suggestions on ways in which collaboration with biomedical practitioners can be strengthened. As one of them noted, “We healers should collaborate with biomedical practitioners. We are not doing that at the moment; we are more often stigmatized and accused of using our medical knowledge for witchcraft to harm people.”²⁸⁶ Yet tension between healers and biomedical practitioners and government officials is common, and this tension has both direct and indirect impacts on establishing joint programs. Biomedical practitioners and some governing officials say healers lack the capacity to treat conditions. Tensions exist between various actors who are directly or indirectly involved in discussions about the epidemic. Such conflicts and tensions appear in the literature and the press, between politicians (the former president for South Africa

²⁸⁴ Interview, Maja Jame, Hinda-Lugeye Magu; May 8, 2010.

²⁸⁵ Interview, Mkobu Mlyano, Kawe Kamo- Ng’wamanga-Magu; August 8, 2010

²⁸⁶ Interview, Geka Kami, Lugeye-Magu, November 10, 2009

Thabo Mbeki) and the international scientific community, between profit-making drug companies and social groups, and between developed and developing countries (Fassin, 2006).

Healers can be involved in programs such as awareness campaigns and can help identify the ill. They can also assume the role of health care providers for people affected by HIV/AIDS. A new approach is required that will tap information and practices from healers for both formal and informal preventive and curative approaches. Healers are widely recognized in their communities for their knowledge and skills. It is unlikely that relying solely on advances in scientific knowledge, free market forces, or simplistic notions of human rights and interpersonal ethics will provide sufficient solutions to problems within an unstable complex system (Benatar quoting Homer-Dixon, 2000).

The former Tanzanian president, Benjamin Mkapa, said, “The threat of the contemporary world requires acknowledgement and engagement of the traditional knowledge.” He also noted that the different problems facing the world today, including HIV/AIDS, require holistic approaches that will combine the use of modern and traditional means in order to achieve sustainable development goals (Mkapa, 2004 pp. 1-3). Streamlining the relationship between healers and biomedical practitioners will help address the ongoing intersections and interferences between traditional healing and biomedical practices that are common inside and outside of medical units (Langwick, 2007). Healers assume the roles of direct and indirect caregivers to people suffering from HIV/AIDS and its opportunistic diseases. Healers could facilitate and encourage testing programs and adherence to drug regimens among the people visiting them.

Access and adherence to effective therapy for the HIV/AIDS regimen can be improved if healers are actively involved. Traditional healers interact with HIV/AIDS infected people at different stages of the disease with or without patients' knowledge. The basis of Farmer's (2007; 2008) argument, together with the need for "accompaniment" to ensure effective and efficient therapies for HIV/AIDS people, is analogous to the widely discussed topic by Feierman and Janzen (1978) about the role of relatives, friends, and traditional healers in therapeutic management programs to support the infirm. Available statistics concerning the magnitude of HIV/AIDS rely heavily on registered cases in conventional medical facilities. Tracking the number of people who choose traditional medicine is a challenge, and no exact figures are available to represent the role of traditional medicines for HIV/AIDS patients. Healers interact with a large segment of the population infected with HIV/AIDS; therefore, their involvement in counseling, testing, and distribution of ARVs can reduce the burden from already overwhelmed biomedical units and staff.

The HIV/AIDS epidemic has been a driver for collaborative efforts between healers and biomedical practitioners (Stangeland et al, 2008). These examples of collaborative work appear in different forms that are both formal and informal. On some occasions, healers and biomedical practitioners have worked together to provide combined physiological and physical support to people infected with HIV/AIDS. In my fieldwork I have recorded numerous cases in which healers attended patients who oscillated between biomedical and traditional medicinal services. A healer interviewed in Misungwi explains such interactions:

There was a young boy who came to me; he once travelled to Zanzibar, he was ill and I treated him for two weeks. Then he was dehydrated, but with good

collaboration with biomedical practitioners *aliongezewa maji* (he received a transfusion), at the hospital. His relatives were told to bring him back to me for my therapies after receiving drips of water. I recall his condition started improving and was able to ride a bicycle. However, his condition changed, the symptoms reappeared and he had diarrhea. Initially we felt that our medicine was effective for his improved conditions, but new symptoms emerged and this time there was persistent nausea. HIV/AIDS is manifested by multiple complications. After three weeks, I told his relative to take him back to the hospital, because his condition was not improving. I knew he had been to the hospital three times. His relatives and I reached a consensus that my medicines, like those obtained from the hospital, were not working. His relatives pleaded to me saying, ‘Please just attend him no matter the outcome; we do not have any option now; we have tried everything; and let us pray to the Lord for anything that will happen.’²⁸⁷

When probed if the patient survived, the healer lamented that the patient died even after returning to the hospital, where he was admitted for three days.²⁸⁸ Despite recognition that HIV/AIDS is incurable, Tanzanian traditional medicines have shown positive effects for some conditions associated with HIV/AIDS, including a direct effect on the virus, immunostimulatory activity, and treatment of infections (Moshi, 2005). My fieldwork has uncovered the way in which healers have offered advice on actions, diets, and lifestyles aimed at improving the health of people suffering from HIV/AIDS.

CONCLUSION

This chapter has demonstrated that the institution of traditional medicine is not a closed system; rather, it is dynamic and responsive to social, political, environmental and epidemiological transformations. For instance, my study demonstrates that HIV/AIDS significantly affects the geospatial arrangements of healers in societies. Some of the

²⁸⁷ Interview, Mabilia Tobi, Nkolati Mbarika, April 15, 2010.

²⁸⁸ Interview, Mabilia Tobi, Nkolati Mbarika, April 15, 2010.

interviewed healers noted that they have migrated to new places after being invited by clients in need of HIV/AIDS therapies. The epidemic has also created new forms of medical interaction between different kinds of medical therapies.

Experience in Mwanza indicates that emerging health problems, such as HIV/AIDS and the associated rising medical costs dictated by global institutions and market forces, provide an increasing opportunity for traditional healers to treat infected people. The current situation offers a unique opportunity to compare non-Western medicinal practices to those offered by biomedical institutions. Conventional/Western HIV/AIDS interventions most often use universal approaches that might not always be able to address the disease in specific localities throughout a world with various social, cultural, economic, geographical and epidemiological conditions (Mbori-Ngacha & Marum, 2002). Health care interventions have to account for local conditions of a particular region, deviating from the universal approach that has not been successful. The inclusion of traditional healing practitioners and institutions now appears to be a viable and urgent step to assist national and international programs in efforts to combat HIV/AIDS (Campbell and Mzaidume, 2002).

Healers, like biomedical personnel, have worked to find a cure for the disease. They perceive this work as a great opportunity to acquire financial gain while also fulfilling an obligation to serve the community. Healers seem to be in a research mode to find therapies that will be effective against HIV/AIDS. One respondent explained what he observes in society. “Therapies for HIV/AIDS are in high demand, and that is my

focus. I am doing research for effective medicine. I have nine people who are receiving my medicine, and their conditions seem to be improving.”²⁸⁹

Recent Western approaches to addressing HIV/AIDS need to go beyond merely providing antiretroviral drugs. Approaches also need to account for the roles of different actors within and outside affected communities. Traditional healers have proven themselves through their involvement in healing practices. In particular, the rollout of antiretroviral (ARV) therapy is considered to be a juncture where the social relations of healing are newly opened for reconfiguration across biomedical and traditional divides. Traditional healers now form a unit that can influence protection, prevention and “adherence” to ARV therapies.

Farmer and others advocate an ethic of “accompaniment.” Originally anchored in the complexities of antiretroviral and tuberculosis remedy adherence, “accompaniment” has evolved to speak more broadly to support for the sick, who also suffer poverty. The engaged response of traditional healers to health crises linked to HIV/AIDS is based upon the idea that traditional healers provide client-centered, personalized health care that is culturally appropriate, holistic, and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients. This social proximity facilitates communication about diseases and related social issues. Some traditional medical interventions have shown positive results when treating opportunistic infections, such as herpes zoster (Chaze, 2003). However, the broader social and ritual effectiveness of traditional healing is in flux at present and affected by political, environmental, cultural

²⁸⁹ Interview Jomayo Mayoma, Matara village, Sumbugu-Mbarika, Misungwi, March 20, 2010.

and economic conditions. One way in which traditional healing and its actors have faced challenges is examined in the next chapter, which looks at albinocide.

**CHAPTER 7:
ALBINOCIDE ON AFRICA’S EXTRACTIVE FRONTIERS:
MOBILITY, DISABILITY, AND THE CRIMINALIZATION
OF TRADITIONAL HEALING IN TANZANIA**

In this chapter I argue that, while both visible and invisible forms of violence against albinos reported in Tanzania occur in the context of ‘resource violence,’ such violence must also be understood in light of broader historical and contemporary criminalization of traditional medicine as it relates to beliefs regulating ‘resource access.’ Further, I note that albinos engage theories of racialized political identity in unique ways, and help explain changing concepts of marginalization, discrimination and violence under circumstances of rapid social change in Eastern Africa. I use secondary data from the media and firsthand interviews from the Mwanza Region (where many of the killings have taken place) and consider three relevant court cases. I also examine different intervention measures that have been incorporated to respond to the crisis. My interpretation offers a more endogenous view of what I term “albinocide” without neglecting the influence of local and regional politics within a large scale, globalized, extractive industrial post-socialist state.

ALBINOCIDE, THE CONTEXT

People with albinism experience multiple threats in Africa that range from biological vulnerability to the sun to complex social forms of discrimination, stigmatization and isolation. Additionally, they now face widely publicized increases in albino-related murders. In the past three years, fifty-three albinos have been killed in Tanzania, eleven in Burundi, and many others have been left with permanent disabilities (*Thisday* February 15-21, 2010). The practice of killing of people with albinism for their body parts, what I refer to as ‘albinocide,’ ranges, geographically, across Eastern, Southern, and Central Africa. The World Health Organization defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (Krug et al. 2002). Violence related to the extraction and trading of human body parts has been reported in different parts of the world (Sanders 2001; Scheper-Hughes 2001). In Liberia, for instance, *The Economist* reported recent ritual killings known as *gboyo*, during which people’s extracted body parts are used in sorcery to bring power and wealth (*The Economist* February 5, 2011). Perceived notions of albino identity cast them as “other,” in part due to the physiological feature of pale skin as a result of a lack of melanin. Such ostracizing attitudes perpetuate both social and physical forms of violence against people with albinism.

Apart from the killings, the graves of deceased albinos, where not fortified with concrete, have been exhumed and their bodies have been mutilated. There is no safe landscape for people with albinism due to informal markets for their body parts and

because of the wider social stigmatization of albinism that these markets reflect and reinforce. These body parts are commodities; their value depends upon aspects such as age, the type of part, and if the part was taken from an individual who was alive or dead. Research suggests that women and children are the two most targeted groups in the albino community.²⁹⁰ Scholarship to date has argued that these forms of violence against albinos are linked to particular political economies engaged in competition for unpredictable resources.

The recently reported incidences of albinocide in Tanzania's most violent extractive frontiers of fishing and precious minerals (diamonds and gold) have garnered attention in social theory literatures. Scholars note the superstitious beliefs among fishermen and artisanal miners that albino body parts bring good luck in fishing or mining have led to albinocide. Popular media sources also report that witchdoctors are involved as processors of the albino parts to enable some participants in extractive industries to use these parts as "charms" or talismans.

These beliefs about the value of albinos present a conceptual challenge that this paper takes up: violent acts against albinos are irreducible and unique in the ways they target particular types of marginalized individuals and mark them, making their bodies into commodities or even fetishized objects. Yet such acts also link, structurally, to ritualized abuses of "others" who fit uncomfortably within the strained social fabric of some African communities in which disease burdens are high and in which economic

²⁹⁰. Notes one source: "At least 26 albinos, mostly women and children, were killed and mutilated over the past year" (*Daily News* October 20, 2008). Another story reveals that: "The latest victim was a seven-month old baby." (*The Guardian* July 23, .2008)

circumstances exacerbate family fragmentation and/or overextension of household resources in extended family systems.

The majority of these crimes have been reported within the Eastern African regions of Mwanza and Shinyanga (known as Sukumaland) and Mara. These regions are endowed with an abundance of both renewable (fish) and non-renewable resources (gold and diamonds). In addition, two regions of Sukumaland are recognized as loci of the infamous 21st century murders of elderly women who were suspected witches (Green 2005; Mesaki 2009; Bryceson, Jønsson et al. 2010). At an online venue, one person observed, “There have been since last year albino killings in Tanzania as the albino organs, particularly genitals, limbs, breasts, fingers and the tongue are reportedly in high demand by wealth-seekers to bring luck charms in mining and fishing activities in the Lake Victoria regions.”²⁹¹

Others have written sporadically about discrimination against people with albinism, but nothing has equalled the fascination this discrimination has received in the past three years through the local and international press. Beyond print media, digital media, such as *Youtube.com*, has showcased a wide range of videos related to violence against albinos. Regional resource extraction and its consequences have been featured in international media as well. One of the most notable films was Hubert Sauper’s 2004 documentary, *Darwin’s Nightmare*. This film’s stark images recorded the victimization of local populations linked to the global fishing and arms-trading industries.

²⁹¹. Source <<http://www.groundreport.com/Opinion/Superstitious-Albino-Killings-in-Tanzania-Must-Sto>>, accessed November 13, 2010.

Previously, the social science literature on albinism focused on identity representation in society through media such as novels (Baker 2008). The relationship between media attention and the intensification of these forms of violence raises many unanswered questions about peace and security for people with albinism (Dave-Odigie 2010). Albinocide, defined here as a series of structural effects and actual events, provides a complicated glimpse at the links between processes of racialized identities, competition over natural resources, the changing roles of witchcraft and traditional medicine, and the valuation of body parts in resource access and accumulation. Unlike some media sources seeking to dramatize violence against albinos, by employing the term albinocide I seek to urgently engage academics, policy makers, and other stakeholders to critically analyse the root cause of the problem and to find effective, holistic ways to deal with multiple forms of violence happening to people with albinism.

ALBINISM AS A CATALYST FOR VIOLENCE

“Albinism” refers to a genetic condition that is phenotypically displayed in one’s eyes, hair (“blonde” or “ginger”) and skin. The most common albinism is called ‘*Oculocutaneous albinism*,’ an inherited biological condition that is found among people in Africa (Kromberg and Jenkins 1982; Simona 2004). Biologically, albinism is defined by the melanin deficiency that impairs skin, hair and eye coloration. This condition makes albinos susceptible to diseases such as skin cancer and eye illnesses. Melanin protects humans from the ultraviolet rays emitted by the sun (Kromberg and Jenkins 1982). The skin coloration of albinos causes some people to view them as “freaks of nature” or objects of morbid curiosity (Baker 2008: 92). “Not being black enough” is

stigmatizing in Sub-Saharan Africa where black identity dominates. Some believe albinism is a hybridization of black and white people. In Kenya, for instance, husbands whose wives have albino children have accused these wives of committing adultery with white men.²⁹² As a result, ninety percent of all albinos in the region are raised by single mothers.

Societies have given a social and spiritual context to albinism. Baker has used the terms ‘lacking’ or ‘inadequate’ to explain the biological impairment, thus leading to the perception of physical weakness and mental inadequacy (Baker 2008: 94). Racism manifests in the way in which albinos are largely stereotyped as *bahati mbaya* (a curse or bad luck).

Discrimination against albinos appears in popular culture, such as arts, movies, and fiction, in which they are often portrayed as possessors of supernatural power. This presentation is not only found in Africa. For instance, in the 1978 comic movie *Foul Play*, directed by Colin Higgins, an albino character is a killer. *The Da Vinci Code*, a 2006 film directed by Ron Howard, based upon a novel of the same name by Dan Brown, stereotypes an albino character as a uniquely disturbing killer. These evil and violent stereotypes reflect Baker’s observation that people with albinism constantly deal with distorted perceptions of their personal qualities. (Baker 2008: 96).

Among certain cultures in East Africa, albinism is seen as a unique identity that may confer charms to obtain power and wealth. Within this cultural perception, melanin deficiency embeds value into body parts that can be exchanged for money. Another view

²⁹². ‘Crackdown on witchdoctors after albinos killed to harvest body parts’ <<http://www.independent.co.uk/news/world/africa/crackdown-on-witchdoctors-after-albinos-killed-to-harvest-body-parts-804545.html>> accessed October 4, 2010

holds that the deficiency of melanin makes the body valueless. This devaluation is expressed in ambivalence toward the survival of albino infants. In interviews, healers noted some families concealed the birth and presence of an albino in a family. Illnesses and deaths of the albinos are generally undisclosed. This devaluation in life is contradicted by the value of body parts upon death. Graves of deceased albinos are exhumed and their body parts are extracted and sold.

It is easy to generalize the issue of albinicide and to link it directly to mining or fishing. However, it is also possible to confine the problem to beliefs of a particular group, such as the Sukuma people in Sukumaland. Incidences in Tanzania provide an opportunity to analyse a multitude of critical socioeconomic, political and resources access issues facing people in Sub-Saharan Africa in relation to albino killings. I argue against the generalizations about mining and fishing groups, linking their histories of regional mobility and a lack of sedentary self-sufficiency to new forms of stigmatization.

I first consider the details and circumstances of reported violence against albinos and the disaggregated view of the traditional healing sector as it relates to categories such as “witchdoctor” or “sorcerer.” I also discuss the histories of criminalization of traditional healing, and the difficulties in using the existing legal framework to address violence against people with albinism. Finally, I view the possibilities for better protection of albinos.

Sources I draw from include informal interviews with traditional healers, legal experts, and individuals working in different social organizations. Additionally, I analyse both local and international media sources to capture the magnitude of the problem and the context in which people with albinism are harmed. To establish the legal mechanisms

that deal with violence against albinos, I examine human rights reports and national legislation regarding witchcraft and human trafficking. I also discuss three related legal cases and offer historical sources on traditional healing, witchcraft, murder and security for people with albinism.

ALBINOCIDE: A NEW FORM OF VIOLENCE

Albinocide is a type of violence shaped by power relations and inequality. There are obvious parallels between albinocide, gendercide, and infanticide. The killing of infants, or “infanticide,” has occurred in societies via violence or abandonment. In some cases, infants are killed because of gender preference and selection. This particular form of infanticide is termed gendercide.²⁹³

In all these cases, the victims are from vulnerable populations. These forms of violence are all widespread, protracted, and are hard to prosecute. Sometimes these acts of violence are social phenomena that extend from specific beliefs. Albino women are targets of rape because of the belief that HIV can be cured by having sex with an albino woman (Cimpric 2010). This belief in the curative power of sex with specific females extends to enslaved young girls. Witchdoctors tell males that they need to sexually engage with disabled, virginal girls in order to accumulate wealth.²⁹⁴

A lack of healthful living conditions is another way in which albinos are targeted within East African communities. Albinos are often denied basic necessities that protect them from harmful ultraviolet radiation to which they are particularly vulnerable. Over

²⁹³. ‘Gendercide: What Happened to 100 Million Baby Girls’ *The Economist* (March 6-12, .2010: 13).

²⁹⁴. *Tanzania Daima*, November 13, 2008.

90 percent of people with albinism in Tanzania die by age 30-35 due to skin cancer caused by exposure to the sun.²⁹⁵ A general lack of social services results in low socioeconomic status and poor living standards for albinos. A low socioeconomic status and the resulting poor living conditions strongly imply a lack of power to compete in daily life. Albinos are more vulnerable to illnesses (Luande, Henschke et al. 1985). They are also more likely to experience violence due to neglect from family members and society.

Recent social science has offered detailed examinations of the violence of advancing capitalism in post-socialist Africa as it relates to changing anthropologies of the body, trade, magic, and biological integrity (Comaroff and Comaroff 2002; Moore and Sanders 2001; West 2008). One teacher in a Mwanza school associated albinocide with witchdoctors' activities:

Witchdoctors are to blame for albinocide, particularly when they promise people to get rich by using body parts. I remember harvesting of skin was reported in the past; that period passed; then there was a time when human fat was sought; and albinos are now a target. Examining these events closely you will notice that witchdoctors are the cause of murder of elderly people accused to be witches.²⁹⁶

Sanders (2001) shows incidences of killings related to witchcraft. In the Mbeya Region (southwest Tanzania) in 1999, youths, were killed and skinned. Their skins were sold in countries such as Malawi, Zambia, and the Democratic Republic of Congo for purported witchcraft activities (p.160). Sanders argues that the reported incidences of

²⁹⁵. Source: Under the Same Sun <<http://www.underthesamesun.com/projects.php>> accessed January 1,2011. See also (Luande et al. 1985)

²⁹⁶. Interview, Salu Salu, School official, Misungwi-Mwanza, August 23, 2010.

occult idioms and practices were a result of changes in local social and economic conditions brought about by structural adjustment programs imposed by the World Bank and the International Monetary Fund. Sanders notes, “With the structural adjustment’s relentless imposition of ‘free market’, the possibilities for marketing the occult appear virtually limitless” (162). Approximately ten years later, incidences of albinicide have been reported within and outside of Tanzania. Both the earlier murder-for-skin-extraction and the recent albinocides indicate a link to motives that are temporally and spatially dependent upon existing political, socioeconomic, and cultural conditions.

Bryceson *et al.* (2010) and Tanner (2010) realize that social scientists must do more than merely convey the stories and images that characterize the gossip, rumour, practice, and popular media concerning various issues. Social scientists must tackle the powerful underlying assumptions in mainstream accounts and in well-intentioned advocacy politics. While acknowledging the symbolically potent and highly ritualized nature of some of the violence in question, social scientists must offer humane and historically accurate analyses of human inequality at multiple levels.

Despite widely reported incidents, few of the reported perpetrators of albinicide have been traditional healers (Bryceson *et al.* 2010). Challenging widely accepted beliefs, there is no evidence to show miners or fishermen have been involved in the crimes. Tanner (2010) has argued that this kind of violence in this particular region (Sukumaland) should be dealt with by understanding distress within the region via a cultural paradigm that accepts the power to perform and prevent acts of evil between people.

Symbolic usage of body parts, according to Tanner (2010), is a result of peoples' logic that governs behaviour and patterns of survival as part of their inherited knowledge. The demand for body parts appears when advanced technologies have enabled the exploitation and invasion of large geographic areas in search of all possible natural resources. Marginalized groups, including small-scale fishermen and miners, are challenged by poor technology and weak capital. They are presented as desperate customers of witchdoctors who exploit the hopes of individuals in these marginalized groups to gain a competitive edge in exploiting natural resources. However, the large sums of money paid to people in possession of body parts suggest that small-scale fishermen and miners may not be the only clients. The accusations against these marginalized groups are, as Kohnert (1996) suggests, the effect of widespread beliefs that the disadvantaged are the ones who take advantage.

The focus on miners, fishermen, and traditional healers ignores historical, political and economic factors, as well as cultural aspects that shape the beliefs, practices, and social order in different communities. Historically, Sukuma people have undergone different socioeconomic and environmental changes. Though some of these changes were naturally induced, others were the result of government policies and interventions that disrupted peoples' relationships with their environment and the way in which their social networks were created. For instance, "Ujamaa villages,"²⁹⁷ implemented in 1970s, disrupted the Sukuma people's modes of production and kinship.

²⁹⁷. Ujamaa villages represent the grand development project in the 1970s by the government of Tanzania to resettle people in designated villages designed to have access to social services and its people work in communal farms.

The emphasis on cash crops by both the colonial and postcolonial governments created new economic meanings for work for the Sukama people. Likewise, the magnitude of HIV/AIDS not only restructured health practices; the division of labour in societies was impacted as well. The expansion of extractive industries has brought about changes in politics, economics, environment, and social conditions. Because of the close association between investors and the government, small-scale miners and fishermen appear to be marginalized. Marginalized groups use different strategies to seek attention. These strategies include both violent and non-violent approaches.²⁹⁸ For instance, according to *The Citizen* (March 22, 2010), police arrested a suspected member of an armed gang who stormed the compound of the Geita Gold Mine in Mwanza and ran away with boxes of explosives. The same newspaper reported the recovery of two engine boats and the arrest of four suspects who allegedly attacked and robbed fishermen at the Igombe village in Mwanza.²⁹⁹ These various crimes related to large-scale industry in the region suggest albinicide is, as with these crimes, a symptom of structural socioeconomic and cultural forms that make people with albinism vulnerable to physical violence.

MARGINALIZATION OF PEOPLE WITH ALBINISM

People with albinism experience both physical and structural forms of violence. Structural conditions often reinforce physical violence against albinos. Structural forms

²⁹⁸. CMI (2006): Benefit Stream from Mining in Tanzania Case Studies from Geita and Mererani <<http://bora.cmi.no/dspace/bitstream/10202/80/1/Report%20R%202006-11.pdf>> accessed 28.12.2010

²⁹⁹. *The Citizen* Online, Armed gang grabs explosives at mine. <http://www.thecitizen.co.tz/news/4-national-news/831-armed-gang-grabs-explosives-at-mine.html>> accessed 26.2.2011

of violence, due to changing political, economic and cultural traditions, prevail when people face restrictions that prevent them from performing to their full potential (Galtung 1969; Cohen 1999; Tsing 1993; Ho 2007). Galtung (1969) emphasizes the economic, political, and social conditions that negatively impact full realization of life expectancy. Structurally, the current prevailing system has not allowed equal access to social services among albinos and has thus rendered them susceptible to diseases and shorter life spans. Albinos' susceptibility to disease and shorter life spans is due to unequal access to social services, a circumstance that is exacerbated by poor living conditions and physical violence. A teacher interviewed in a school for children with special needs observed:

Albino-children are not given equal opportunities like others. Albinos enrolled in primary school are over-aged, relative to their peers mainly because parents felt embarrassed to have children with albinism and they confine them. When the problem of albino killings started that is when we started seeing parents bringing their children to this school for security reasons and because the problem became a national issue. (Salu 2010 int.)³⁰⁰

Another school official noted,

“The vast majority of families with their children who are at school discriminate against their albino-children; they never follow the progress of their children. The society has not acknowledged that these albino-children are like other children, or other people that have made a contribution to build the nation (Salum 2010 Int).”³⁰¹

Violence against albinos is also manifested through superstitious beliefs and racial classifications. The deficiency of melanin among albinos has been given different meanings by different actors, including people with aspirations for power and wealth, with witches, and with traditional healers. This issue of racial classification has given rise

³⁰⁰. Interview, Salu Salu, School official, Misungwi-Mwanza Primary School, August 23, 2010.

³⁰¹. Interview, Jumanne Ngese Salum, School official, Misungwi-Mwanza, August 23, 2010.

to the now infamous statement *zeluzelu ni dili* (“Albino is a business deal.”) This virulent concept threatens the survival of people with albinism because of the superstitions that place their body parts in demand.

The use of materials from humans is not a new phenomenon in magic medicines, witchcraft, and biomedicine (Cory 1949; Masquelier 1993: 18; Moore and Sanders 2001; Forsyth 2006; Scheper-Hughes 2001). Intentional killings for body parts have been reported in other countries, such as Zambia, Malawi, the Democratic Republic of Congo, Liberia, Kenya, and Uganda (Moore and Sanders 2001; Caplan 2010). The multitude of locations for such actions suggests that the phenomenon is widespread and does not only affect albinos.³⁰²

When viewed through an economic lens, the context in which albinos are killed is not within the purported therapeutic processes but rather is in response to “economic maladies” afflicting society. Some people believe those with biological deficiencies possess lucky charms for economic opportunities. The phrase “economic maladies” in the context of this paper refers to a situation in which people feel that they are afflicted with money-deficiency ailments. For them, the economic malady is incurable by legitimate income generating activities, and they must consult individuals who claim to be wealth-makers. In turn, the wealth-makers themselves are afflicted with economic maladies. Desperation for their own cure, the wealth-makers propagate ideas of using body parts and ignore the physical and psychological harms they inflict on people with albinism.

³⁰². ‘In the early 2000s six people were believed to have been killed and skinned in Mbeya Region, south-west of Tanzania.’ <<http://www.groundreport.com/Opinion/>> accessed May 12, 2008

A Kenyan man was recently convicted of trafficking an albino Kenyan to Mwanza (Tanzania), for use as body parts. This cross-border trafficking suggests the problem of albinocide is not confined to Mwanza or Sukumaland. The Kenyan man deceived the victim and managed to take him to Mwanza in order to sell him alive. When the kidnapper was charged with trafficking persons and abductions, his defence pointed blame at a traditional healer who sought albino body parts.³⁰³

The victim of this trafficking scheme experienced discrimination in his homeland. He was economically vulnerable for many of the social and institutional reasons outlined above. He lacked the necessary education to compete in the job market. He was desperate for any job within or outside his own country. This desperation gave his kidnapper the opportunity to befriend him. Both agreed to travel to Tanzania with the promise that the target would be offered a job. This incident reveals the way in which human trafficking is a result of discrimination, a lack of support for people with disabilities, and a lack of economic opportunities.

This incident also illustrates the extent to which albinocide plays into anxieties about the integrity of borders and the control of trade and movement across them. The problem of human trafficking was also reported in Rukwa (one of the central regions in Tanzania). There police apprehended a Tanzanian fisherman who wanted to sell his wife with albinism to Congolese businessmen for TSH. 3.6 million (equivalent to US \$2,500).

³⁰³. *Habari Leo* August 19, 2010.

These businessmen reportedly visited Tanzania to buy fish;³⁰⁴ however, they were seeking human body parts.

The human trafficking from Kenya, and the solicitation of body parts by businessmen from the DRC suggest that the violence against people with albinism should be understood in a broader context: human trafficking and international trade in a globalized economy. Globalization is the defining trend in the world today, intensifying interactions and ideas among people and integrating markets (Fukuda-Parr 2003). As these cases regarding albino trafficking show, globalization extends to illegal trade, including trafficking humans for their body parts.

In order to understand and respond to incidents of violence against people with albinism, it is necessary to consider racialized political identity, and the nature and extent to which violence against albinos takes place. Other considerations include the relationship between albinicide and other acts of violence in a globalized world, the specific roles of different actors, the violence of extractive economies, and the power or predation of false healers and witchdoctors. These kinds of nested marginalization are key to my my arguments.

ANALYSES OF ALBINOCIDE

Various hypotheses and theories have emerged to explain the causes of albinicide. Hirschler (2004) argues: “Conflicts are an integral part of societal interaction and the more dynamically societies change, the more conflicts between different

³⁰⁴. Police in Rukwa region are holding a fisherman for allegedly attempting to sell his albino wife to Congolese businessmen for 3.6m (*Daily News*, 12.12.2008).

interests, identities, opinions and demands are likely to occur.” The social tensions in Tanzania emerged as an outcome of various groups’ struggles for inclusion in political and economic activities. These tensions create conditions for violence and crime. Farmer (2004) and others have used the term “structural violence” to explain how political and economic factors determine risks of diseases and violence. Secondary social-structural factors, such as stigma, superstition, and social tensions, are also part of structural violence.

Understanding the problem of albinocide requires an approach that addresses these nested forms of marginalization for traditional healers, artisanal miners, fishermen, and people with disabilities. Cohen (1999) and Tsing (1993) have both described, in different disciplines, the “marginality” within already disadvantaged or “out of the way” populations in ways that grapple with biological as well as social components of vulnerability and stigma. Their work allows useful disaggregation within categories of victims and perpetrators, what Guyer and Richards (1996) have called adequate “phenomenological resolution” (borrowing from Atran (1990) in crafting their call for better environmental anthropology.)

STRUCTURAL VIOLENCE AND EXTRACTIVE INDUSTRY IN ALBINOCIDE

Despite its socialist history, the government of Tanzania has not been immune to pressure from the World Bank (WB) and the International Monetary Fund (IMF) to privatize social services and economic activities. The expansion of multi-national extractive industries is a result of neoliberal policies initiated by the government since the late 1980s. According to Emel and Huber (2008), these neoliberal economic

arrangements create risk and externalities not fully accounted for, such as violence, health problems, and environmental damage. Such policies escalate poverty, force people to live in congested slums, and push more children into the streets (De la Barra 1998). Neoliberal policies were adapted in the 1980s as a rescue mission to facilitate the economic growth of countries described as underdeveloped. Advocates for neoliberal policies claimed state control was an ineffective way to supervise economic activities compared to a free market that allowed foreign investments. However, free trade economic policies have not been inclusive; the gap between rich and poor has increased due to unequal access to resources.

The adoption of neoliberal policies opened access to natural resources to multinational corporations; small-scale fishermen and miners were forced to relocate in large numbers to areas with weak resource bases. Large investment groups have the capital to purchase or create new technologies to maximize profit. These technologies, and the government policies that facilitate them, penetrate and disorient communities' interactions with their land resources as well as their social networks. Existing mineral titles in Tanzania reflect an existing power hierarchy that creates unequal access to mineral resources. Small-scale, artisanal mining in Tanzania is marginalized. Despite government efforts to formalize artisanal mining activities, inequality persists, most often due to unequal control over value-producing assets (Fisher 2007).

Bryceson *et al.* (2010) focus on factors such as decreased economic opportunities and competition over access to and acquisition of mineral resources. These struggles foster superstitious beliefs. *Waganga* (traditional healers) use witchcraft and sorcery to make luck charms whose demand increases as artisanal miners' attempts to control

economic events decreases. Within the free-trade extractive environment of the mining and fishing industries, analogous ideas emerged. The extraction of body parts to create power-gathering charms enabled magic to facilitate the harvesting of fish and the extraction of precious minerals. These two industrial sectors, fishing and mining, are associated with albino killings.

Investors in the mining sector have enjoyed lucrative profits because they are not charged import duties or value-added taxes. They have a royalty rate of three percent, the lowest in the world. When quoting data from the Tanzania Chamber of Minerals and Energy, Emel and Huber (2008) report that, in 2005, the government of Tanzania received approximately \$30,000,000 in royalties and corporate income taxes while the mining companies produced \$640,000,000 worth of gold. Often these mining contracts are negotiated in secret; the public is denied the opportunity to negotiate or realize any benefits from the resources exploited.³⁰⁵ This government secrecy regarding contracts with multi-national industries provoked debate about the need to review mining legislations and contracts.³⁰⁶ Those who supported input from communities argued that the government had failed to protect mineral resources for local residents.

The way in which resource extraction was negotiated in secret provided new means for people to rationalize their responses to their changing socioeconomic conditions. In his article, “Albino killing is an economic problem,” Faraja Mgwabati reported that approximately 50 albinos have been killed since 2007. The culprits were

³⁰⁵. The concealment behind mining contracts is a persisting problem that has caused conflicts and misunderstanding in Tanzania (*Majira*, November 19, 2009).

³⁰⁶. *Rai* May 15-21, 2003

accused of trading the body parts from their victims to as many as 10 million businessmen (*Daily News*, November 23, 2009)

SOCIAL STRUCTURES AND VIOLENT ACTS

Traditional healing utilizes herbs and divination for healing, appeasing, curing, and to protect subjects from harm. A person who practices traditional medicine is called a *mganga* (traditional healer). Traditional healers, diviners, and shehs supply different kinds of medicine for protection and success (Green 2005). Tanner notes that albino killing should be examined by connecting Sukuma cultural beliefs and identity to other social discourses, such as the HIV/AIDS epidemic (2010). However, the cultural beliefs surrounding traditional healing, witchcraft, and sorcery are themselves contradictory and shifting. Albino killings are based upon a belief that has prevailed in some communities, that albino charms confer power and wealth.

Examples of this belief abound. In Geita (a mining district in Mwanza) seven people were left unconscious after consuming a concoction that was supposed to make them rich. The concoction was obtained from a fugitive traditional healer who subsequently disappeared with the victims' money and mobile phones. The victims subjected themselves to incisions and the smearing of medicines on their bodies to boost their fortunes and to attract more customers to their businesses.³⁰⁷ Medicine for wealth poses threats to clients as well as albinos.

³⁰⁷. *The Citizen* online edition, March 15, 2010 <<http://www.thecitizen.co.tz/sunday-citizen/40-sunday-citizen-news/701-healer-renders-patients-unconscious-robs-them.html>> accessed November 14, 2010

Sanders (2010) notes politicians and businessmen consult these *mgangas* to secure medicine for success (p.169). Caplan (2010) captures the dynamic by noting, “The contemporary manifestations of the occult, at the level of both ideas and practices, are varied and must be related to present-day social, economic and political circumstances.”

Incidents reported in news and other literatures indicate that artisanal miners, fisherman and others consult traditional healers for therapies related to their activities. Since miners and fishermen are accused of using body parts, the healers who are assumed to be the mediators of body parts are targeted by law enforcement. In January 2009, healers’ operations were restricted.

One journalist, Ndimara Tegambwage, responded to the reports of albinocide by asking *Baada ya Albino, Nani? Mwito wa Elimu, Mabadiliko?* (“After Albinos Who’s Next? The Call for Transformative Education”). He suggested that every incidence of albino killing has the same characteristic: in some way or another a *mganga* (witchdoctor) was involved. First, the *mganga* gives assailants protective medicines so that they will not be caught when killing for body parts. Then the *mganga* appears to receive and process body parts before they are used as “charms for wealth” (“*dawa ya utajiri*”) (*Mwanahalisi* January 14-20, 2009). The question arises: is a *mganga* a healer or a practitioner of witchcraft?

DISTINCTION BETWEEN WITCHCRAFT AND TRADITIONAL HEALING

Discourse surrounding albino killings often conflates witchcraft with traditional healing. Understanding how these activities differ, both temporally and spatially, is crucial to identifying the underlying causes of albino killings. Both healing and

witchcraft activities use magic to produce positive and negative results (Kohnert 1996). Magic is a combination of practices that involve the use of chemicals, poisons, and other materials associated with supernatural agency. The practices are aimed at secretly causing harm or death through occult powers (Green 2005). Nearly every magical rite includes the use of a medicine endowed with supernatural power (Cory 1949). These medicines consist of two classes of ingredients. The first contains a number of specified roots or other tree parts; the second contains the *chingira*. (pl. *shingira*). The first class contains plants, for the most part. The second class contains a wide variety of plants and animals, and also human excreta and body parts (Cory 1949). Cory argues that the second class of ingredients, *shingira*, determines the purpose of the magic medicine. Stroken calls *shingira* the metaphorical additive in every recipe (Stroken 2008). A healer interviewed in Mwanza noted that *shingira* are not traditionally associated with albinos or human body parts:

We do not use *shingira* from albinos, these people have existed even in the past; why were they not attacked in the past; our inherited healing knowledge is genuine; there was no such thing *shingira* from albinos; all the materials I have inherited, there is no *shingira* from human body parts. If they (albino body parts) were not used in the past, how do you start using them now? If they had an application in traditional healing, then we could have used them in the past and all albinos could have been exterminated (Malambo 2010 int).³⁰⁸

DISTINCTIONS BETWEEN WITCHCRAFT AND SORCERY

Witchcraft ideas and accusations persist in some societies in Africa and the use of witchcraft has been linked to misfortunes, such as premature death, illness, job loss, traffic accidents and failure in production and reproduction. People's achievements, as

³⁰⁸. Interview Sagali Malambo, Traditional healer, Misungwi- Mwanza, March 14, 2010.

well as misfortunes, are also attributed to witchcraft rather than good luck, talent, or hard work (Ashforth 2005; Green 2005; Meneses 2004; Mesaki 2009; Stroken 2010). Witchcraft involves various practices: sorcery, enchantment, bewitching, the use of instruments of witchcrafts, the purported exercise of any occult power, and the purported possession of any occult knowledge (Mesaki 2009). Witchcraft involves clandestine actions motivated by hate, jealousy, greed, consumption, and a get-rich-quick mentality (Ashforth 2005; Forsyth 2006; Green 2005; Mesaki 2009; Meneses 2004; Stroeken 2010).

In Sukumaland, sorcerers inflict harm by using magic medicines that contain human ingredients linked to both the victim and desired result (Tanner 1956). Sorcerers' activities have earned them a reputation as the agents responsible for community and individual misfortune. Misfortunes are characterized by two causal relationships. First, the ill will of peers with whom some identifiable tension exists; second, the reckless manipulation of human material for strictly individual purposes (Austen 1993: 91). The use of body parts has been a contested issue in the field of traditional medicines, though some studies suggest that human excreta, body parts, and fluids have been parts of ingredient used in witchcraft and sorcery (Tanner 2010; Cory 1949).

Austen (1993) draws attention to African belief systems as an amalgamation of beliefs in which maximizing resource access and acquisition requires the application of an arbitrary and destructive external power (104). The events surrounding albino killings widely reported in Tanzania seem to have witchcraft motives because these killings involve the belief in mediums and the use of body parts intended for supernatural and

occult causes.³⁰⁹ Poverty and hopelessness may be an important driver of witchcraft when appeals to authorities are ineffective in attempts to deal with problems (Mesaki 2009).

Historically, in Sukumaland, ad hoc groups were hired to kill accused or suspected witches (Heald 1986). Sungusungu vigilantism (covered in Chapter 3) was another form of locally organized security efforts. Suspected witches were asked to confess and to denounce witchcraft before they were punished (Abrahamas, 1987; Bukurura, 1995; Gunderson, 2010; Paciotti and Hadley 2005) Sungusungu emerged in a time of social transformation. Heald notes that the development of Sungusungu was related to the demobilization of the Tanzanian army following the end of the war with Uganda in 1979. Sungusungu was the subsequent shift from an external war to an internal turmoil that the regular forces of the state were unable to control (Heald, 2002).

Violence against people with albinism indicates the lack of security in the region to deal with crime and witchcraft. People in Sukumaland tend to deal with both perceived risks and existing threats. Perceived risks include fear of unknown consequences attributed to witchcraft. In addition, murder, robbery, and cattle rustling are common in this part of the country. In the past, people have responded to these threats by establishing protection and response measures that are individual, family, and community oriented. The establishment of Sungusungu vigilantism in the early 1980s was a communal measure to secure order, establish security, and to deal with criminals. Vigilantism filled a void created by ineffective governance (Abrahamas 1987; Heald 2002; Heald 2005; Paciotti *et al.* 2005).

³⁰⁹. The 1928 ordinance was about holding of beliefs in mediums and things/phenomenon such as charms (Mesaki, 2009).

The literature indicates Sungusungu controlled crimes in the regions, to the extent that the government gave it limited authority (Paciotti *et al.* 2005). The dramatic decrease in crime rates during the early 1990s, for instance, was attributed to Sungusungu.³¹⁰ Operations by Sungusungu have declined over time, however, due to a deterioration of support from the government and a decreased interest in working for Sungusungu among people in the region. Sungusungu vigilantism leaders complained that the police force demoralized people by harassing and jailing them instead of supporting them. A quote from the commander for Sungusungu in Mwanza reveals the frustration:

Initially we collaborated well with the police; we consulted police and they allowed us to arrest and penalize the criminals, but not nowadays, we cannot do that, if you punish the criminals, you might find yourself remanded. We do not have any authority with cases (Mulingi 2010 int.).³¹¹

Diminishing powers for Sungusungu and continued harassment from government agencies have created a security void that has resulted in an increase in reported crimes. However, this is by no means the only reason that crimes occur. The next section examines conditions that led to governmental restriction of healers' operations.

BEYOND THE STRUCTURAL: TOWARD A POLITICS OF ALBINOCIDE

News articles and various court cases indicate that some healers have been accused, arrested, and jailed for the crimes related to albino killings. There are always

³¹⁰. In early 90s “the peak period of Sungusungu interventions” (i.e. after the empowerment of the 1989 Act) the country experienced a drop on crime rate of about 60 percent and 72 percent in mugging and armed robberies, respectively with 20 percent drop on crime rate in burglaries, and up to 24 percent drop in assault cases. <http://www.unhabitat.org/downloads/docs/1825_12883_sungusungu.pdf > accessed January 4, 2011.

³¹¹. Interview, Musa Mulingi, Leader for a Sungusungu army, Magu, Mwanza, March 15, 2010.

ambiguities when characterizing both traditional medicine and witchcraft; both are complex, diverse, and secretive. This ambiguity surrounding traditional medicine and witchcraft forced the government to restrict all activities by healers.

Fortune tellers, diviners, and traditional healers, exist in many societies and are consulted about the possibilities or outcome of undertaking particular tasks, such as competition for political leadership, protection and expansion of business ventures, and the securing of love and marriages (Comaroff and Comaroff 1993; Moore and Sanders; 2001; Rowlands and Warnier 1988). An official in one of the primary schools in Mwanza had a similar observation:

Imani potofu (misguided beliefs) confuse many people. These beliefs are propagated by healers, a trusted group in societies assumed of dealing with all problems. That is why, whenever they (healers) ask people to bring anything, people will do it. In the past, healers asked clients to bring animals or chicken. Now they tell wealth-seekers to bring albino body parts. People are trapped because they want to be rich, that is why albinos have become a business deal' (Salum 2010 int.).³¹²

The albino killings emerged in 2007, one year after the government initiated the difficult project of registering all traditional healers in Tanzania. The government sought to recognize traditional healers as key health care providers, as stipulated by the Traditional Medicine Act of 2002. The escalation of albino killings reversed the registration process; in January 2009 the government announced it was revoking the previously offered licenses. At the same time, the government decided that there was sufficient evidence to implicate healers in crimes against albinos. In September 2010, the government revived the registration process and issued new directives to healers that defined acceptable practices within traditional medicine. One regulation prohibited the

³¹². Interview, Jumanne Ngese Salum, School official, Misungwi –Mwanza, August 23, 2010.

use of human body parts. As of February 2011, healers are now required to register in their municipality through local governments.³¹³

Before the government reintroduced the registration process, healers had to respond to the accusations that implicated them in albino killings. Some healers noted that the field of traditional medicine is threatened due to this accusation by the government, and by individuals who commit crimes in the name of traditional medicine:

These (traditional healing) practices are at risk because healers were threatened that they will be caught as culprits of albino killings. The popularity of traditional medicine is declining; and the trust in the field is no longer there. There is also a lot of *utapeli* [con men, racketeers] because many people claim to practice medicine who, in fact, do not know anything about medicine (Bakwandya 2010 int.).³¹⁴

Other healers appealed to the government with the argument that prohibiting healers' activities was wrong:

The government should stop disturbing us; we were probed and accused of killing albinos; and we were disappointed! My knowledge in the field of traditional medicine is *asili* (inherited from my ancestors), and those biomedical practitioners of yours do not know anything, now there are many diseases that they cannot treat, but we can treat (diseases) using traditional medicines (Kaneba 2010 int.)³¹⁵

Healers noted that the government has not given adequate support to the field of traditional medicine, while the proposed interventions are designed to collect money through payments made for licenses. Even if support had been forthcoming, many healers are suspicious that invitations to seminars are extended so the government can investigate, not support, them:

³¹³. *DailyNews* (February 3, 2011) 'Traditional healers to be officially registered' <<http://www.dailynews.co.tz/home/?n=16932&cat=home>> accessed February 10, 2011.

³¹⁴. Interview, Zalo Bakwandya, Traditional healer, Magu-Mwanza, May 11, 2010.

³¹⁵. Interview, Magole Kaneba, Traditional healer, Magu-Mwanza, May 10, .2010.

The government is not helping us, rather is taking our money and forcing us to pay for the permits. Though, last year, we were gathered for what was said to be a seminar. In fact, it was a follow-up by the government to probe healers on albino killings. We were probed by being tricked (*tunahojiwa kwa kutegwa tegwa*) how do you treat, then you say.’ ‘I treat like this and that’. Then they ask you, ‘what do you mix in your medicines?’ Then you tell them, but that does not mean traditional healers are the cause of albino killings. There is a healer who was asked in Dar es Salaam, and he responded, ‘in which medicine will I put an albino.’ And, myself I do not know even its uses (Mabeyo 2010 int.).³¹⁶

Some of the interviewed healers have questioned government revocation of their licenses, arguing that they have been in the field of traditional medicine for many years. They argue the community depends on them and, thus, ethics compel them to attend to peoples’ needs. “Our task is to treat people for their diseases; that is not wrong. When it happens that patients are visiting you --- will you just leave them --- without attending them? I am sure you will treat them (Gwagala 2010 int.).”³¹⁷

However, healers also sympathize with the government’s decision and acknowledge there are individuals “polluting” and “contaminating” the field of traditional medicine by committing crimes: *samaki mmoja akioza wote wameoza* (if one fish rots, they all rot). Narratives from healers and actions taken by the government show the non-convergence of ideas about the role of traditional healing practitioners in societies as discussed in the following sections.

DIVINATION: A HARMING INTERVENTION?

Divination is one of the more controversial aspects of traditional healing practices that cause debate between government officials and traditional healers. The government

³¹⁶. Interview, Lusaka Mabeyo, Traditional healer Magu-Mwanza, May 14, 2010.

³¹⁷. Interview, Kala Gwagala, Traditional healer. Magu-Mwanza, May 4, 2010.

feels that divination is a source of violence in the field of traditional medicine; however, healers feel that divination is a major component of healing practices.

Diviners are individuals who mediate between people and the spiritual world; they play a role in making diagnoses and in prescribing cures or solutions to problems (Wijsen and Tanner 2002). Historically, diviners were advisors to rulers, such as Chiefs, about rain seasons, threats against and prospects of communities, and were used to identify witches (Green 2005; Mesaki 2009). The study by Green and Makhubu (1989) indicates that about 40 percent of the roughly 5400 healers operating in Swaziland are diviners.

Healers argue that healing is a holistic system. Therefore, restricting some aspects, such as divination, affects their whole practice (Gwagala 2010 int.).³¹⁸ Nevertheless, a letter accessed from an interviewed healer in Mwanza city during fieldwork in 2006 includes instructions from a Municipal Medical Officer stating the licenses prohibit divination.

ACCUSATIONS AND CRIMINALIZATION OF TRADITIONAL HEALERS

The criminal case of *Republic vs. Masumbuko Matata @ Madata and 2 others* included a healer famous for his divinations (*kutula mhigi*). The three defendants in this case were charged with killing and amputating an albino to obtain body parts. One of the accomplices was promised Tsh. 400,000.00 (Equivalent to US\$ 270.00) for his

³¹⁸. Ibid.

participation.³¹⁹ The case reveals a sense of confusion in the government's prosecution because aspects of witchcraft were not mentioned. All traditional healers do not engage in witchcraft, as noted in earlier testimony from healers under investigation by governmental authorities. However, the government's accusation seemed to rest upon the defendant's role as a traditional healer, rather than his use of witchcraft. His profession, not his actions, were on trial. Rather than view this as an isolated crime, the government has used this conviction and similar circumstances to revoke permits used by healers and, thus, implicate all healers in the actions of a few.

On September 18, 2010, the daily newspaper *Mtanzania* included the headline, “*Sangoma akamatwa na lita ya mafuta na nifupa ya binadamu Sengerema*” (A traditional healer, 50 years old, was apprehended with a litre of fat and bones that are suspected to be from a human from the Sengerema district in Mwanza).³²⁰ The term *Sangoma* literally refers to traditional healers (herbalists and diviners) in South Africa, but is still popularly used in Tanzania to refer to traditional healers as well as witchdoctors.

The above incidents indicate how all traditional healers have been implicated in albino killings undertaken by a few. Albino killing is considered witchcraft because it involves the use of body parts that are obtained maliciously and intended for occult purposes. The use of body parts is explained as witchcraft, according to the Witchcraft Act, Cap. 18 of the Revised Edition of the Law of Tanzania. “Witchcraft” includes sorcery, enchantment, bewitching, and the use of witchcraft. These designations include

³¹⁹. Criminal case no 24 of 2009, High Court of Tanzania sitting at Kahama in Criminal Session, the judgment was delivered on September 23, 2009; Tsh. 400.000 (US \$27,000 where US \$1 for Tsh. 1500/=).

³²⁰. *Mtanzania*, September 18, 2010.

the purported exercise of any occult power and the purported possession of any occult knowledge (Section 2 of the Witchcraft Act, Cap.18 of the Revised Edition.). The law incriminates any person who intentionally causes death, disease, injury or misfortune to any community, person, animal or property. However, the government failed to identify the specific individuals who committed crimes after the law was written; instead, the government restricted all healers' activities, as discussed in the next section.

THE GOVERNMENT INTERVENTIONS: REVOKING HEALERS' LICENSES

The government ban on healers' licenses in January 2009 was based upon evidence that some healers were involved in the killing of people with albinism.³²¹ Opponents of the ban argue that all healers are blamed for the actions of a few and suggest the health sector will be severely impacted by restricting more than 75,000 healers operating in Tanzania.

Healers in the Misungwi district composed a letter to the District Commissioner in March 2009 in which they acknowledged the order by the government. However, healers requested the government allow them to practice traditional medicines because, otherwise, more than 60 percent of the population will not have access to health care services. Practicing medicine is a source of income and demolishing healers' facilities affect their profession.³²² Ndimara sums up the role of traditional healers in his article, *Serikali haiwezi kufuta utamaduni* (It is impossible for the government to abolish culture), on website for the Tanzanian weekly newspaper *Raia Mwema*. He notes the

³²¹. <<http://www.ippmedia.com/frontend/index.php?l=21380>> accessed October 2.10, 2010.

³²². Letter from healers to the District Commissioner wrote on March 7, 2009 in Misungwi, Mwanza.

government can revoke the licenses, but traditional medicine practices are permanent because they are part of the culture. The main problems, according to Tegambwage, are that the government does not have expertise in the field of traditional medicine, and that no standards for the practice of traditional medicines exist. He argues that the government's action to ban healers was too quick and it punished the majority who were not involved in criminal acts.³²³

Healers argue that the government should deal with traditional medicine as an institution aimed at bringing order to society, rather than suspend the entire field of traditional medicines. The government decision to lift the ban in September 2010 was in recognition of the fact that more than 60 percent of the population depends on traditional medicines. The restriction of healers' services infers that the available biomedical services meet the needs of the entire population of Tanzania. However, biomedical institutions have never managed to cater to the health care needs of the populations in Sub-Saharan African countries. Restricting healers' operations increases the number of people utilizing biomedical units, which are already overcrowded.

Licensing traditional healers will not, on its own, create security for albinos because there are only a few individuals in the field who are criminals. Even so, people with albinism pleaded with and challenged the government to institute effective mechanism to counter possible spates of albino killings after the ban on healers was lifted.

³²³. *Mwanahalisi* (February 4, 2009) <<http://www.mwanahalisi.co.tz/>> accessed October 5, 2010.

In March 2009, the government embarked upon a program to conduct secret ballots that would help to identify criminals involved in killing the elderly, people with disabilities (albinos) and *majambazi* (bandits).³²⁴ Prime Minister Mizengo Pinda, speaking at the 17th parliament session, noted that the killing of albinos has destroyed Tanzanian credibility. He stated that cooperation is needed to fight against atrocities happening to albinos. In addition, he revealed that, during the period of four months, from June to October 2009, forty-seven people with albinism had been killed, and there were one hundred and nine suspects accused of murder. The measures taken by the government are short-term. The effectiveness of government efforts is hampered by the limitation of the legal framework that does not adequately address the problem of witchcraft. .

AN EMERGING LEGAL FRAMEWORK FOR PROTECTING PEOPLE WITH ALBINISM

The Constitution of the United Republic of Tanzania of 1977 (as amended) under Article 14 provides that, “every person has the right to live and to the protection of his life by the society in accordance with the law.” The law clearly stipulates that social, economic, and political affairs should not violate human rights. Article 12 provides that all human beings are born free and that all are equal. Article 13 stipulates that all people are equal before the Law and are entitled, without any discrimination, to the protection and equality before the Law. Violence against those with albinism curtails their right to

³²⁴. 2009 Human Rights Report Tanzania
<<http://www.state.gov/g/drl/rls/hrrpt/2009/af/135980.htm>> accessed January 13, 2011

liberty and freedom of movement under Article 17. Clearly, the government seeks to codify equality and human rights for all. Discrimination against albinos is a violation of the Constitution; killing them violates the Constitution and is contrary to the Penal Code: Act Cap 16 of the Law of Tanzania R.E 2002, Section 197, which states, “it is unlawful to kill and it is punishable by death penalty once a person is found guilty of murder by the competent court of Law.”

International legal instruments protect the right to life. In the Universal Declaration of Human Rights of 1948-1998, Article 3 provides that everyone has the right to Life Liberty and Security of Person.³²⁵ The above laws have been used to prosecute people who have committed crimes against people with albinism.

LIMITATIONS WITHIN THE LEGAL STRUCTURE TO DEAL WITH ALBINOCIDE

Legally the discussion of witchcraft, sorcery and traditional medicine is not without controversy and ambiguity. Court decisions are complicated by several issues, including the distinction between witchcraft and traditional medicines and by whether to apply a Penal Code or the Witchcraft Act. For instance, in order to convict a person practicing witchcraft, an accused individual must be apprehended at the crime scene. This rarely happens because witchcraft acts are undertaken in secrecy.

Over the years, the government has relied on a legal mechanism that was established during the colonial era (The Hon TA int.),³²⁶ a point noted by Mesaki (2009).

³²⁵. The Universal Declaration of Human Rights of 1948 Adapted and Proclaimed by General Assembly Resolution 217A (III) of 10 December 1948 and 1966 <<http://www.un.org/en/documents/udhr/index.shtml>> accessed December 12, 2010.

³²⁶. Interview, The. Hon. TA, Legal Expert, Kisutu, Dar es Salaam, April 6, 2010.

The Witchcraft Act was one of the oppressive laws that the Nyalali Commission recommended for repeal because it infringed upon human rights³²⁷ by giving power and authority to the District Commissioners to punish convicted persons by relocating them without their consent (The Hon HM int.³²⁸ & The Hon AI int.³²⁹).

After minor amendments of the law in 1956 that emphasized punishable offences (Mesaki 2009), the Witchcraft Act became binding and enforceable. If a person is caught with materials pertaining to acts of witchcraft, he may be charged with witchcraft offences (The Hon AI int.).³³⁰ Despite amendments added to the Act, a definition of witchcraft materials is not specified. In addition, witchcraft practices are hard to prove; even when a person is found in possession of albino body parts it is difficult to take action against them (The Hon AI int.).³³¹ Prosecuting witchcraft is very difficult because consent of the DPP (Director of Public Prosecution) is required to prosecute such offenses. Furthermore, witchcraft is not clearly defined in the Witchcraft Act and the Act does not account for actions related to witchcraft. Thus it is difficult to know what particular offences relate to witchcraft crimes (The Hon HM int.).³³² Because of these limitations and confusions, the Witchcraft Act has rarely been used to prosecute people accused of practicing witchcraft. In addition, albinism is not protected under the Witchcraft Act. Even if the law can be fully applied, albino killers are charged with murder under Section 196 of the Penal Code Cap 16 of the Laws of Tanzania as revised

³²⁷. The Nyalali Commission was appointed by the president in 1992 (Mesaki 2009).

³²⁸. Interview, The Hon. HM, Legal expert, Kisutu, Dar es Salaam, April 6, 2010.

³²⁹. Interview, The Hon. AI, Legal expert, Kisutu, Dar es Salaam, April 6, 2010.

³³⁰. Ibid.

³³¹. Ibid.

³³². Interview, The Hon. HM, Legal expert, Kisutu, Dar es Salaam, April 6, 2010.

in 2002 (The Hon HM int.).³³³ Likewise, those who are found with albino body parts are charged under the Penal Code (supra) under Section 222A thereto, and not charged under the Witchcraft Act. Despite the limitations within existing laws, numerous cases have been heard regarding the murder of albinos and criminals have been prosecuted.³³⁴

In *Republic v. Kazimili Mashauri & Mathias Italange @ Mahona*,³³⁵ the High Court of Tanzania in Mwanza sentenced Kazimili Mashauri to death by hanging for the killing of an albino. The accused was charged with the offence of “murder contrary to the Penal Code.”³³⁶ Despite suggestions that this was an albino killing motivated by witchcraft, Mashauri and Italange were charged under Section 196 of the Penal Code. While Kazimili Mashauri was found guilty of killing an albino and received the death penalty, Mathias Italange was acquitted due to a lack of evidence, despite circumstances that indicated his involvement in the crime was motivated by the possession of body parts. The Witchcraft Act requires evidence that body parts were used for witchcraft; in situation like this it is difficult to acquire that proof.

The Penal Code stipulates that it is a criminal offence to be found in possession of the body parts of any person. The prosecutors did not charge the accused with possession of body parts because there was no physical evidence. This case illustrates the limitation of the legal framework in reference to witchcraft. For instance, the jury did not focus on

³³³. Ibid.

³³⁴. Source: “by September there were an estimated 90 persons being held for crimes against people with albinism. By year's end the courts had sentenced a total of seven persons to death for attacks on persons with albinism” (2009 Human Rights Report Tanzania 2009) <http://www.state.gov/g/drl/rls/hrrpt/2009/af/135980.htm> accessed December 14, 2010.

³³⁵. Criminal case no 42 of 2009. United Republic of Tanzania.

³³⁶. *Penal Code* Cap 16 Revised Edition 2002 of the Laws of Tanzania. <http://www.un.org/Depts/los/LEGISLATIONANDTREATIES/PDFFILES/TZA_penal_code.pdf> accessed December 12, 2010

issues such as the purpose of the body parts or where were they were intended to be used. There were also gaps in the legal framework when attempting to identify different actors involved in the use of body parts from albinos.

CONCLUSION

The atrocities inflicted upon albinos symbolize the on-going structural and physical forms of violence against people with disabilities worldwide. These acts of violence happen to people who are vulnerable due to the denial of social services, a lack of access of healthcare, and a lack of education. Killings of people with albinism are influenced by the fragmentation of the social fabric as well as the capture of resources by global industrial entities.

Any analysis of the albinocide problem should not be confined to the problem to traditional healers, artisanal miners, and fishermen operating in the geographically blurred boundaries of Sukumaland. Such a limitation obscures holistic intervention measures. Such limitation is also a colossal omission of the entire web of connectivity that involves interactions between labor, capital and markets in economic frontiers in cultures that feature different groups with different motives. The problem of albinocide is a reiteration of social relations in globalized economies. The prime suspects in albinocides are also among marginalized groups and include healers, artisanal miners and fishermen. However, the prime suspects are not the ultimate consumers of the products originating in Sukumaland. Instead, these products travel across nations. Addressing the problem of albinocide requires an analytical move beyond a structural argument about blame and victimization.

Multiple factors contribute to the violence against albinos. These factors include perceptions and practices related to power seeking, power consolidation and wealth accumulation via the use of supernatural power and occultism for resources access and acquisitions. Additionally, global economic conditions that influence disparities in societies impact albinos. Gaps exist in the legal framework in relation to crimes motivated by witchcraft, in locally managed security systems, such as Sungusungu, and in the monitoring of activities of different groups of people who claim to be healers.

People with disabilities and impairments are less likely to be involved in the decision-making processes that affect their lives. Their needs are more likely to be ignored and neglected. In addition, they suffer from programs designed by individuals who do not acknowledge limitations that exist for people with disabilities (Nussbaum 2006).

In spite of present treatment, people with disabilities are citizens with full human rights; societies need to acknowledge and address their need for care, education, self-respect, activity, and friendship (Nussbaum 2006: 98). A new approach is required. This approach should seek to empower people with disabilities by allowing them to speak about their concerns. Their opinions must be incorporated when making informed decisions. People with albinism require protection from ongoing killings. They also need support mechanisms to ensure that they receive adequate social services and health care geared to their particular vulnerabilities. Protection against discrimination for people with disabilities must extend to all aspects of life, including, but not limited to, employment,

housing, and legal services, as it is stipulated in the Universal Declaration of Human Rights Article 25 (1).³³⁷

³³⁷. Everyone has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

PART III: CHANGING ECOLOGIES OF HEALING
CHAPTER 8:
ECOLOGIES OF HEALING NARRATIVES OF SOCIAL
CHANGE, ENVIRONMENTAL GOVERNANCE AND
LIVELIHOOD STRATEGIES AMONG HEALERS

Traditional healers are significantly affected by changes happening in the environment; their work is intrinsically linked to the quality of ecological conditions. They interact with the environment on a daily basis, particularly when seeking medicinal flora, fauna and minerals. Healers' continued interactions with ecological systems enable them to acquire unique environmental knowledge and to record changes as they occur. This chapter considers this knowledge, its role within healers' complex livelihoods, its relationship to both historical and present day conservationist concerns, and its possible role in emerging environmental governance. More specifically, in this chapter I present healers' perspectives and practices in relation to environmental change happening in the Lake Victoria basin. I start this chapter by capturing a narrative from a healer who explains how the field of traditional medicine in Mwanza is affected by ecological transformation and the loss of species due to human activities in Lake Victoria.

Ecological Changes in Lake Victoria: Impacts to healers, An Otters' Scenario

Jomayo Mayoma is a healer and the leader of a dancing group. He is in his early fifties and resides in Matara-Sumbugu, in Mwanza. Mayoma gave an eloquent scientific explanation detailing the logic of associations in food webs and how disruption of the food web (for example, caused by the disappearance of some species in Lake Victoria) is impacting traditional medicine. He discussed the relationship between otters (an aquatic mammal important in their practice) and changes that are taking place in the Lake Victoria ecosystem, and linked both to traditional medicine:

Declining fish resources in Lake Victoria: “We have this Lake (Victoria) around us, but fish have disappeared; *sato* (tilapia) are no longer of the same size we used to see in the past. They have just become small like *fulu* (*Haplochromis* species) or *dagaa* (sardine); they are so small – how are you going to eat them? I do not know what is causing this (disappearance of aquatic resources) perhaps there is *ujanja wa kina namna*, (some sort of tricks) such as using small-mesh nets that even *furu* cannot go through, and even *dagaa* will all be picked. It is called *kumbakumba* (shoving all) with those *machandarua* (mosquito nets), even other species that were supposed to grow are picked before their maturity. The bad thing is when the exercise is a daily routine; you do it today, and tomorrow fish exploitation continues in the same area. That is why fish in the lake are declining. That is a real situation!”

Species used in traditional medicine in Lake Victoria: “In the past there was an abundance of fish; there were plenty of both tilapia and *ningu* (*Labeo victorianus*). There were many other different varieties but now some species have disappeared.” When asked if there are any species disappearing that are also of medicinal use or used as *shingila* (important additives in traditional medicine e.g. adding potency of medicine), he said: “*Utu-fina – fina* (otters) – do not exist anymore; you will never see them, they are very few and it is very difficult to see them. There are no more otters; they are very important holding additives in our medicine! (*Tufina hamna fina ndio huwa jikabizaga shidimi shise – viunganishi vyetu!*). Ten years will pass without seeing them; people see them after such a long time. Still they are very expensive for their parts. You will need to

exchange a cow in order to get a small skin; it is very valuable, that is why they are in high demand. But they do not exist now.”

Threats to medicinal fauna in Lake Victoria: When asked about the habitats for otters, he noted, “They only thrived in the Lake, but you can’t find them now. They never go into dams and in rivers; for them it is just in the lake, hunting and eating fish.” Pressing further about what has caused the disappearance of the otter, his noted, “I think it is that the fish that they eat have disappeared, therefore otters have lacked their food. That is what we blame.”

Domino and cascade effects in Lake Victoria: “We can’t even see the dead ones; it is very difficult seeing them. Maybe these otters have followed the fish; maybe that is the situation of ‘how the world is’ (*liwelelo duhu*) that they are gone (this could suggest why the other species that have disappeared will never be seen). That is what I wanted to say, ‘There are not many otters now.’ In my life, I have just seen only two of them and now at the age of fifty only two! It is not easy to see them!”

Other medicinal fauna: “But, we can still access other species used in our therapies, for instance *mang’wina* (crocodiles). There are a lot of them; for them, getting them is not a problem.” When asked how about other important animals that are hard to get, the healer responded, “Skin from *lala* (impala) is used for rituals and is called *ihogejo lya lala* (ritual based on impala); we did rituals using parts such as a skin from leopard (*twahogejaga na masubi*). *Chui* (Leopard) is used for *ihogelo*; and a lion is as well used for our rituals (*ne e-nshimba ihogejo lise*); all of them are used for our rituals. We use skin from leopards in crowning our leaders (*batale bise baneba*). Those are large wild animals we use.³³⁸

The above narratives show healers’ understanding of ecological changes happening in the Lake Victoria basin region. The narratives are supported by scientific studies conducted in the region that, to a large extent, have ignored the contribution of healers. Other studies have indicated the medicinal significance of otters and the way in which they are becoming an endangered species. For instance, traditional medicine says that eating the flesh from an otter relieves asthma and chest pain; the dried secretion of

³³⁸ Interview, Jomayo Mayoma, Matara-Sumbugu, Mbarika – Misungwi; March 20, 2010

the common otter obtained from its perineal sac is used for rheumatism, joint and chest pain, and to improve eyesight (Padmanabhan and Sujana, 2008). Some studies have indicated that otter blood is used in Ayurvedic medicine to treat epilepsy (Nagulu et al. 1999). A healer, Muhangwa Mahushi, noted that one of the functions of the otter in therapy is to treat erectile dysfunction,³³⁹ much like rhino horn has been used in the Middle East (Low and Tan, 2007)

Some studies support healers' narratives about changes happening in Lake Victoria, particularly regarding the disappearance of otters and programs in place to protect them. The literature indicates that otters were in abundance in the past; they have since become endangered mammals in Lake Victoria. Now different groups are taking measures to protect them. Worldwide, the International Otter Survival Fund works collaboratively with local conservation groups in East Africa, such as the Kisumu Teachers Otter Conservation Development Group (KISTOC).³⁴⁰ The main food of otters is cichlids and crabs (Kruuk and Goundswaard, 1990). The decline in the numbers of otters, reported in the early 1990s, was attributed to changes in species composition after the introduction of Nile perch (Kruuk and Goundswaard, 1990). The Nile perch became a dominant species in the Lake in the late 1980s. This fish is a carnivore that has diminished the survival rate of native cichlids, one of the major food sources for otters (Kruuk and Goundswaard, 1990). Nile tilapia is another species that has been seriously impacted by the introduction of Nile perch (Geheb et al. 2008).

³³⁹ Interview, Muha Malushi, Kanyerere-Usagara, April 7, 2010

³⁴⁰ Source Otters News from the International Otter Survival Fund No 52 Spring 2009 <http://www.otter.org/images/adminPDFs/55.pdf> accessed June 10, 2011, additional information at http://library.sandiegozoo.org/factsheets/spotnecked_otter/spotted_necked_otter.html

A study by Vitule et al. (2009) indicated that the introduction of the Nile perch has contributed to the decline of other carnivore populations in the lake and has caused the extinction of several species, including the African spotted-necked otter (*Lutra maculicollis*), and the African clawless otter (*Aonyx capensis*). The impacts of Nile perch in Lake Victoria extend from the ecological system to social systems, as portrayed in the documentary, *Darwin's Nightmare*, by Hubert Sauper (released in 2004). The film depicts the social impacts associated with the introduction of the Nile perch in Lake Victoria, including poor management of remaining fish bones and heads. These are now processed as a source of diet and income in the region.

However, some studies indicate that fishing with seine-nets (*kokolo*) could have been the reason for the disappearance of small-sized otters (Kruuk and Goundswaard, 1990). Other causes attributed to their disappearance are conditions such as the pollution of Lake Victoria in recent years. Different studies have indicated that Lake Victoria has become the recipient of pollutants from different sources: industry, agriculture, municipal waste discharge, and atmospheric deposition. These pollutants consist of biological and chemical oxygen-demanding substances, nutrients, heavy metals, and pesticides (Scheren et al, 2000; Taylor et al. 2005)

There are other threatened species said to have medicinal use in Lake Victoria. They, too, are among species reported to have disappeared, or nearly disappeared. One healer noted a fish species known as *ningu* (*Labeo victorianus*), also on the verge of

disappearance. It is used in the preparation of medicine for *nhondo ya mholela* (a fish to cure wounds that have not responded to other medication).³⁴¹

Programs in Kenya, Tanzania and Uganda initiated to revive the ecological system of Lake Victoria, such as the internationally funded Lake Victoria Environmental Management Project (LVEMP), have neglected to involve or consult traditional healers. Likewise, the literature fails to consider how biotic resources in Lake Victoria are used in the field of traditional medicine, or what other effects the disappearance of several species have had on the field of traditional medicine. Activities worldwide remain a major threat for biota, particularly for those that are rare. However, healers do not see themselves as the consumers of these biotic resources that have reached levels of near-extinction. For instance, otters and other wild animals, such as tigers, turtles, pangolins, rhinos, and snakes, are among the species threatened worldwide. They are also among the species that are traded internationally for their medicinal use (Bell et al, 2004). The value of a species in transnational markets for traditional medicine can lead to very rapid decline and extinction.³⁴²

Therefore, in this chapter I expand the view of the widely recognized Sukuma healing practices to other ethnic backgrounds in order to account for inter-cultural and cross-cultural medicinal practices among different actors operating in Mwanza. As Mwanza has become the hub for various economic activities mentioned in Chapters One and Two, and as its informal sector has grown accordingly, healers from other traditions within Tanzania have relocated their practices to Mwanza. Further, a combination of

³⁴¹ Interview, Muha Malushi, Kanyerere-Usagara, April 7, 2010

³⁴² E.g. poaching for cash in Asia; Collection of medicinal fauna.

droughts, climate change, and increasingly rigid and well-policed property boundaries has caused an influx of Maasai from the northern regions of Tanzania. This group has introduced their distinct plant-based medicine and ritual knowledge into the Mwanza region.

Healers form a group that is well informed about ecological changes through their various occupations. In addition to observing and obtaining medicinal flora and fauna, many healers in rural areas also perform other functions, such as agriculture and livestock keeping. In the Magu district, for instance, all of the thirty-two respondents in rural areas characterized farming as their major activity. Twenty-three of them (about 72 percent) owned livestock. Despite their unique understanding of ecological processes, healers' involvements in local, national, regional, and international environmental programs remain peripheral. Likewise, the scientists in the field, particularly in the Lake Victoria basin, tend to generalize environmental impacts on healers' activities and ignore the diversity of traditional healing practices. Ideally, healers could be one of the many actors supporting efforts to understand vulnerabilities and adaptability associated with environmental change. However, they are largely absent as actors in national and regional action plans related to climate and environmental change. The acknowledgement of local actors, such as political leaders and policy makers, and their knowledge, roles, actions, and readiness in regard to climate and resources management appears in the literature (Agrawal and Perrin, 2008; Lemos and Agrawal, 2006).

Both natural and man-made impacts have continued to alter ecological conditions, often affecting the field of traditional medicine. Changes in ecological conditions have two impacts on traditional medicine. First, an increasing number of people suffer from

environment-related illnesses (patient vulnerability). Second, increasingly poor environmental quality affects the availability of medicinal resources, which, in turn, compromises the quality of services offered by traditional healers (healer vulnerability).

In this chapter I trace healers' adaptations to the changing environment by focusing on perceptions and practices that surround current knowledge about health, as well as the production, distribution, and consumption of medical therapies in Mwanza. By spending time with healers, medicinal gatherers and sellers, as well as clients of traditional medicine, I explore issues related to 1) the availability of medicinal resources, 2) the impact of conservation programs, and 3) the access to ritual spaces such as wells, springs, forests, and mountains. Further, using secondary sources, along with archival and oral historical data, I trace how these symbols have changed over time. I also use regional data on climate change and conservation programs. These have global implications; they also shed light on national policies that have altered the social structure of traditional healers.

ENVIRONMENTAL POLICIES AND LEGISLATIONS

Makhubu (1998) notes that, since 1990, the world has seen a rise in international responsibility through initiatives for development, sustainability, and the environment. Among these initiatives is the formation of the Convention on Biological Diversity (CBD), an organization that emphasizes international responsibility to protect and conserve the environment and natural products. The CBD recognizes the value of local/indigenous people with knowledge of medicinal flora and fauna and has provisions for effective use of resources that have medicinal value.

Despite efforts by international agencies to promote the use of traditional medicine and to conserve medicinal flora and fauna, numerous challenges still exist. The issue of obtaining animal parts used for medicinal purposes remains unresolved. Concerns exist related to the decline of traditional health knowledge and environmental degradation as healers' ritual spaces and plant/animal healing products are increasingly subject to environmental degradation and environmental governance/conservation measures. Obtaining animal parts for medical purposes has been a challenge due to declining animal populations, as well as national and international regulations protecting biodiversity (Alves and Rosa, 2005).

Despite the importance of animal parts in the medical field, studies of animals and their body parts used for traditional medicinal purposes have been neglected. Due to restricted access imposed by conservation initiatives, many healers fear being punished for killing animals or for possessing animal parts used in therapies. In this way, national and international efforts aimed at biodiversity conservation conflict with healers' interests. For instance, healers must perform certain rituals in order to appease their deities. Government institutions complicate the position of healers by not acknowledging these deities.

In order to protect and ensure the sustainable use of wildlife resources and the protection and management of wildlife animals, Tanzania is a signator to a number of international agreements. These include the Agreement of the Action Plan for the Environmentally Sound Management of the Common Zambezi River System and the Protocol Concerning Protected Areas and Wildlife Forming the Eastern Africa Region (Nairobi 1985). The government has also ratified the Lusaka Agreement on Cooperative

Enforcement Operation Directed at Illegal Trade in Wild Fauna and Flora (Lusaka, 1994), and the SADC protocol on Wildlife Conservation and Law Enforcement (Maputo, 1999). Other instruments to which the government is signator include the Convention on Biological Diversity (Rio de Janeiro, 1992), the Southern Africa Convention for Wildlife Management (1990), and the Master Plan for the Security of Rhino and Elephant in Southern Africa, (1996).³⁴³ According to Majamba (2001), the above mentioned instruments require the contracting parties to ensure that the hunting industry in their jurisdictions is adequately regulated and controlled to enable sustainable utilization of game.

Restrictions by Government and International Agencies

The initiated programs to protect biodiversity facilitate or restrict access to medicinal resources. When excluded from the management of their local environment, people cease to be “stewards” and become “poachers” (Redclift, 1992; Brown, 1995). Poaching is considered a major threat for many species in Sub-Saharan Africa. Most occurrences are tied to subsistence or illegal commerce; the two phenomena can hardly be distinguished (Jeffrey, 1991). Little information exists about types and levels of wild animals used in therapeutic activities. This lack of information makes it difficult to quantify the effect of traditional medicine on species levels in Tanzania. Hunters are considered the major culprits behind the decline of wildlife and have been accused over the years of threatening the African wildlife population (Gibson and Marks, 1995).

³⁴³ Majamba (2001). “Regulating the Hunting Industry in Tanzania: Reflections on the Legislative, Institutional and Policy Making Frameworks.” ISBN 9987-648-10-X accessed on February 7, 2012 from <http://www.lead.or.tz/publications/regulating.hunting/>

Gibson and Marks note that conservation programs, to a large extent, have excluded rural residents from legal uses of wildlife. This rural population is rarely given incentives to participate in conservation programs. Local communities are excluded despite their subsistence living that is largely dependant upon the natural environment. Gibson and Mark note that when local communities are allowed to participate in the benefits gained from wildlife products, this action creates a new partnership. Those who were considered poachers or criminals become stewards to conserve wild animals. However, efforts to engage local communities in conservation programs to ensure that they are beneficiaries have yet to be realized. More often, those in local communities are seen as destructive agents, particularly when they enter reserves or national parks.

HEALERS' ECOLOGIES OF LIVELIHOOD AND LEADERSHIP

Practices of traditional medicine are most often embedded in other activities such as agriculture and animal husbandry. The social qualities of their work entail hosting patients and their families, often for long periods of time. A healer's reputation may hinge in large part on his or her capacity to nourish and sustain patients during the treatment process. As such, it is not entirely accurate to say that healers rely on agriculture as their primary activity and medicine as a



Figure 23: A healer building *maluli* (storage facilities) to store grains

secondary job; rather, the two spheres are mutually reinforcing. Other, related activities by healers in rural areas include building storage facilities known as *maluli* (storage

facilities for grain) (Figure 23). The infrastructural and economic challenges of producing for household needs and for storing surplus helps healers understand social, health, economic, and environmental challenges in the lives of their clients or patients, and, more broadly, in their communities. Tapping this diverse knowledge from healers to use in different programs, such as conservation and HIV/AIDS prevention and management, will help to meet millennium and sustainable development goals. However, healers' activities are determined by the physical landscape



Figure 24: Livestock keeping among healers in rural areas

in which they opt to live. These landscapes are modified to become therapeutic built environments to accommodate different functions undertaken by healers.

The ability to learn the practice of traditional medicine is affected by changes in society. The reduced interaction between humans and the environment is one of the missing links to gain knowledge of medicinal flora and fauna. Historically, the Maasai people gained their knowledge and practices through continued observation, close attachment to nature, and direct dependence on natural resources (Spear and Waller, 1993). A Maasai healer operating in Mwanza observed it has become difficult for the younger generation to learn about medicine due to social changes and people's reduced interactions with the natural environment:

We have learned about these medicines by growing in an environment that had a lot of vegetation. The young generation now is different when compared to the past. We spent most of our time living in the forest with livestock. We had a lot

of livestock. But now you have *ng'ombe wa kisasa* (hybrid cattle) and life has changed to become more urbanized.³⁴⁴

MEDICAL LANDSCAPES AND HEALERS' THERAPEUTIC BUILT ENVIRONMENTS

As explained in Chapters Two and Three, healers define their medical landscape and the built environment as the physical landscape with necessary objects where therapeutic interventions take place.

The medical landscape includes the biophysical environment, cultural conditions, and livelihood strategies in a particular location aimed at preserving and maintaining wellbeing (Backhaus, 2003).

Healers often select and modify the landscape to make it easy for them to collect, process, and dispense therapies to their clients. In order to understand the medical landscape, one needs to recognize the differences in groups and where they operate. These differences include varying

bodies of medical knowledge and its acquisition, balances between healing practice and



Figure 25: Wards and ancestral shrines in a rural Sukuma healer's compound.



Figure 26: Shelters used for admitted patients and their family members



Figure 27: Shrines at a rural healer's compound

³⁴⁴ Interview, Oleluca Laze, Mwanza City; February 2, 2010.

other activities, religious-based practices (Animist, Christian, or Muslim), ethnicity, and rurality. All these differences are crucial in order to understand the specific materials used by healers, and the nature of their built environments (i.e. more natural or artificial materials.) For instance, healers in rural areas tend to live in isolated places and are more likely to be farmers and livestock keepers. They live in areas where they can easily access medicinal resources that grow wild in surrounding ecosystems. In these areas they tend to have ancestral shrines and wards believed to be homes of spirits necessary for diagnosis and prescriptions for their patients (Figures 25, 26, and 27).

Sukuma healers in rural areas, the majority of whom are neither Christian nor Muslim, are more likely to have their residential premises surrounded with a fence of



Figure 28: A healer's compound surrounded by Mnyaa plant

mnyaa (*Euphorbia tirucalli* L. plant Figure 28) or shrubs for privacy and security. Other healers opt for stones to surround their premises. Their houses are of the *msonge* (round) type, particularly their treating rooms. Roofs are made of thatch but also have *lupingus* (shells collected from the ocean) and snail-shells on top.

Social change may be observed by changes in housing materials. Previously, most healers' houses were made of clay and roofed by grasses; now a majority of healers have concrete houses with corrugated iron or aluminum sheet roofs. However, some affluent healers who would opt for such modern construction materials noted that they could not

build concrete houses because the *wakurugenzi* (ancestral spirits) would not be at home in such structures.³⁴⁵

The outside environment of Muslim healers might not be distinguishable from non-healers' houses. However, the interiors, particularly treating rooms, will be quite distinct. These rooms have sheets on the floor painted with Arabic calligraphy and pictures of the moon. They also contain a Quran, colored carpets, black and red clothes, storage facilities for medicines and have *ubani* (incense) and *udi* (aromatic aloe) burning.

Urban areas, on the other hand, constitute different groups of healers with different ethnic backgrounds, religions, and educations. Their medical landscapes also vary depending on their socioeconomic status. In addition, healers in urban areas increasingly have adapted to new technologies



Figure 29: Healers in urban area

of processing, storing, packaging, advertising and prescribing their medicine (Figure 29). They advertise their medicine with signs to display the diseases they treat as well as the prices for the medicines they sell. These arrangements illustrate both the broader dynamics of regional displacement and the specific solutions within cities to respond to security and infrastructure challenges.

³⁴⁵ Interview, Majukano, Nkolati, Mbarika misungwi, April 15, 2010

Many Maasai healers, for instance, have their operations in Mwanza city. Most of them locate their tables in Kilombero-Milongo Street, at the city center, one of the areas that has many people passing through (See for instance, Figure 30). Maasai healers tend to hang up ring and bead

ornaments and lists of medicines and their prices; many wear their famous Maasai attire known as *lubega*. Umbrella stands



Figure 30: Milongo Street where Maasai healers sell medicine

where Maasai healers sell their medicines showcased on tables. According to one of the Maasai healers interviewed, city authorities in Mwanza have instructed them to not to have permanent shelters for their activities. However, each could use at least three

umbrellas to create shade (Figure 30 & 31). The total cost is about TSH 270,000 (equivalent to US \$180) or TSH 90,000 (US \$60.00) per umbrella. These umbrellas are seen as opportunities for advertisement by mobile phone,



Figure 31: Umbrella shades used by Maasai healers in Mwanza

beverage, and other companies that characterize the urbanization and expansion of Mwanza city. These companies have volunteered to give free umbrellas to Maasai healers in the area as a way to advertise their businesses and to indicate support for the healers.

This association between healers and companies like beverage or telephone companies is a symbiotic relationship and partnership between actors operating in Mwanza. Durkheim showed this interactive process and social cohesion between different actors with varied beliefs indicates an emergence of industrialized and complex societies known as “organic solidarity” (Durkheim 1947). In practical terms, however, this umbrella shading does not seem to be enough to protect medicine from the sun, dust, and vehicular particulates in the city. Exposure to these conditions compromises the quality and efficacy of medicines sold in the city. However, the Maasai prefer to operate at the city center instead of other sites with permanent shelter because they can easily get customers in urban areas. One healer noted, “When I am out of the city it will be difficult getting customers”³⁴⁶ The Maasai have even justified their presence at this site by suggesting that they have reduced crime thanks to their publicly known histories as fearless warriors (Coast, 2006). The presence of Maasai healers in Mwanza is not only tied to the pull factors in Mwanza, but also push factors in their native lands, including ecological, socioeconomic, and political conditions.

With different groups of healers operating in Mwanza, the region has become a medical field where healers’ fame, legitimacy, and recognition is determined by their economic, cultural, social, and symbolic capital (Samuelsen 2004). Healers seek these different forms of capital by their continued search for medical knowledge from others, by incorporating aspects of biomedicines in their practices, by advertising their therapies, and by migration. All these groups of healers operating in Mwanza have different

³⁴⁶ Interview, Oleluca Laze, Mwanza City, February 2, 2010.

procedures when administering medicines. For instance, after receiving medicine from a Sukuma healer, clients are not supposed to say good-bye when leaving the healers premises. Before treatment, payment is supposed to be made for *kisimba miti* (an initial installment to help collect medicine analogous to a consultation fee in a biomedical system.) Some healers recommend that clients return medicine if they see that it is not helping them. For Muslim healers, no shoes are allowed in the treating rooms and it is mandatory to collect money before treatment for the blessing of the medicine. The distinction between Sukuma, Muslim, and Maasai therapeutic landscapes in Mwanza can be summarized in Table 2.

Table 2: Sukuma, Muslim and Maasai healers in Mwanza region: Similarities and Differences

Sukuma healer (rural)	Muslim healer/	Maasai healer
<ul style="list-style-type: none"> ➤ Black and Red clothes ➤ Spears ➤ Vibuyu (gourds) ➤ A stool to sit ➤ Hides of different animals domestic and wild; feathers ➤ Some Shingila e.g. snake head, scales ➤ Grinding stone for medicine ➤ Plastic, glass, and tin vessels for storing medicine ➤ Clients may sit on the stool or carpet 	<ul style="list-style-type: none"> ➤ Sheets on the floor with varied colors with picture of the moon and Arabic words ➤ <i>Udi</i> (aromatic aloe) (<i>ubani</i> (incense) will be burned ➤ A Quran ➤ Black and Red Clothes ➤ Mkeka –colored carpets ➤ A client will sit on Carpet ➤ Other arabic words and pictures on the wall ➤ Plastic, glass, and tin vessels for storing medicine 	<ul style="list-style-type: none"> ➤ Tables under the shade of umbrellas. ➤ Tables showcasing medicine and ornaments ➤ Plastic, glass, and tin vessels for storing medicine ➤ Clients may be invited to sit on the bench of the Maasai for detailed consultation or receive medication while standing.

LANDSCAPES OF AFFLICTION, INFECTION, PROTECTION AND TREATMENT

Several intersecting literatures address the interaction between human diseases and the environment. Studies in epidemiology and public health are largely based on either behavioral or contextual risk factors for disease transmission through the environment (Batterman et al., 2009). Anthropological studies are largely interested in the ways in which disease is understood cosmologically, cognitively, or by the way it is configured politically in respect to citizenship (Ticktin 2006; Richey, 2008; Nguyen, 2011; Hyde, 2000) or, more broadly, by the various ways in which disease is culturally construed (Lock, 1980). Those in geography detail the specific practices and perspectives that give places or landscapes particular meanings (Basso and Feld, 1996; Escobar, 2001; Massey, 2004; David, 2005; Williams, 1998; Backhaus, 2003). They may also monitor changes in landscape usage over time, with spatially explicit data (Brown et al, 2004; Butt, 2011). My own approach hones in on healers' range of conceptual and practical ways of understanding links between the environment and illnesses. For some, pathogens or agents of illness in the environment are an idea that is analogous to pollution and the presence of germs, and the subsequent health problems these create. Most agree that diseases transmitted through human interaction with the environment can be fatal, either through acute etiologies, or through worsening chronic conditions that lead to death. Healers are aware, also, that witches are said to use the physical landscape as crossroads for their evil intentions. This aim is contrary to the way in which healers use the environment to heal afflicted people. However, healers can protect the environment by using *nk'hago* (protective medicine) to help improve people's health and security.

Interference in human lives through sorcery, attack, or robbery exist on a daily basis in imagination and reality, hence the need for invisible and visible forms of protections. For instance, jealous people with envy eye are always ready to seek destructive medicine to undermine other people's health, business, joy, relationships, sexual life and production activities. People seek out healers/diviners to counter these effects and to render the pursuers less potent in their intents to cause harms.

Pollution and Health in Healers' Worlds

Healers also noted that many places are overcrowded, which allows for easy transmission of communicable diseases. Healers further stated that diseases experienced today are the result of polluted environments, contaminated food, and the consumption of packaged, rather than natural, food.³⁴⁷ One healer relayed a common sentiment that food packaged in cans and shipped from one place to another is more likely to be contaminated. He said such food, "is not safe. In the past people used *samli* (oil made out of cows), which had fewer problems."³⁴⁸ Referring to the major challenges in Mwanza, a healer, Sundili Eli, noted:

Now the major health challenges in Mwanza include stomach and respiratory illnesses due to exposure to contaminated water and dust. Myself, I suffered from respiratory diseases, and when diagnosed I was told that I had germs, but also I was having *presha* (high blood pressure), which I was told was a result of excessive fat in my body.³⁴⁹

³⁴⁷ At the meeting with eight traditional healers and a health official in Mwanza city (Meeting June 27, 2007 at Mwanza Municipal Office),

³⁴⁸ Interview, Hema Shokila Bujora-Kisesa, June 30, 2006,

³⁴⁹ Interview, Sundili Eli, Nyamatala-Magu, April 8, 2010

Another healer observed that the major diseases that trouble people in Mwanza include stomachache and schistosomiasis, a parasitic infection.³⁵⁰ Scientific studies in the region corroborate healers' narratives, noting the high rates of water-borne diseases on the shores of Lake Victoria, particularly among fishing communities (Mwanga et al. 2004). Another study indicated members of the Seventh Day Adventist (SDA) church from Kenya were diagnosed with acute *Schistosoma mansoni* after a trip to Mwanza in 2008 that included swimming in Lake Victoria (Chunge et al. 2011). Similar studies have indicated high rates of schistosomiasis among young women in the Mwanza region.³⁵¹ Schistosomiasis is one of the most important causes of morbidity and mortality, especially among children. Intestinal schistosomiasis caused by *Schistosoma mansoni* is highly endemic and widely spread among the villages surrounding the Lake Victoria shores of Tanzania, with prevalence rates exceeding eighty percent (Mazigo et al. 2011). Different factors that contribute to this disease are the infestation of water hyacinths in Lake Victoria and host vectors for schistosomiasis, such as snails (Ntiba, Kudoja et al. 2001; Malik 2007) The infestation of water hyacinths is a result of nutrient loading from agricultural activities and industrial and municipal wastes transported by surface runoffs entering Lake Victoria.

³⁵⁰ Interview, Petela Buli, Kawe Kamo- Ng'wamanga-Magu; August 8, 2010.

³⁵¹ Researching schistosomiasis in Tanzania: In collaboration with physicians, students, and nurses at Bugando Medical Centre and Weill-Bugando University College of Health Sciences in Mwanza, Tanzania, Dr. Jennifer Downs, a fellow in Infectious Diseases at Weill-Cornell Medical College, is conducting research on schistosomiasis in order to develop effective strategies to diagnose and treat this disease in young women in Tanzania. Dr. Downs and her collaborators have found that the prevalence of schistosomiasis is approximately 20% in young women in rural villages in the Mwanza region < http://weill.cornell.edu/globalhealth/online-global-health-journal/global_health_news/researching_schistosomiasis_in_tanzania/>

Healers knowingly or unknowingly treat many diseases associated with environmental pollution caused by haphazard discharge of effluents from municipalities, including hazardous waste from major hospitals. These wastes enter Lake Victoria untreated, thus causing health risks to the users of lake water. The regional data show the magnitude of waterborne diseases. Amoebic dysentery, diarrhea, and intestinal worms are among top five causes of morbidity in Mwanza region (NBS, & Mwanza Regional Commissioner's Office, 2003). Poor sanitation is one of the major causes of reported incidences of waterborne diseases in third world countries (Machiwa, 2003). Lebel (2003) supports the argument by noting that health conditions of the people are very much affected by environmental conditions and about 3 million children die each from environment related causes.

Risky environment: After receiving a snakebite, a patient visited a healer named Muhangwa Mushi. The patient recounted that she was harvesting sweet potatoes when bitten (Figure 32). Sukuma people in rural areas grow sweet potatoes as one of the major staple foods in the region. Women often tend sweet potatoes farms in wet valleys to supplement other staple food crops, including



Figure 32: Patient suffering from a snake-bite

maize, rice, sorghum, and cassava. Sweet potato leaves create a canopy over the surface of the ground and provide shade for rodents and reptiles. Mushi noted that he receives

different kinds of patients, and people with snakebites are just one group of clients.³⁵² The healer applied a local herb to the fingertip of the client's swollen arm after incisions were made at the site of the bite. A follow-up one-week later at Muhangwa's place revealed significant improvement for this patient; she was subsequently discharged.

Sorcery and witchcraft at crossroads: From the healers' perspective, the environment is also seen as a landscape where practices related to sorcery and witchcraft are executed to inflict harm upon people. For instance, people have placed medicine at *nzila maka* (crossroads) to inflict diseases or harm to other people out of jealousy, for retaliations, and due to social tensions (Hinkkanen, 2009). *Mitego* (traps) are one of the famously known health problems linked to individuals stepping on sorcerous medicine placed at crossroads. According to the interviewed healers, *mitego* are often placed with a targeted person in mind. However, these medicines may have unintended effects on other individuals passing the site where medicine was placed.

Conversely, the physical environment is widely used by healers to nullify harmful medicine. Practices to clear diseases from an individual may require washing at the crossroad so that diseases can be shifted to other individuals who are not protected. In the process of one being cured, the disease or illness is left in the environment before being transmitted to other individuals. In this form of treatment, the disease will escape from an individual that has received medicine and by doing so it jumps to another individual who will step on the site where the ritual was performed.

Both healers and clients describe the transmission of disease from one individual to another. An individual might be sick for a long time and then, in search of therapy, that

³⁵² Observation and Interview, Muha Malushi, Kanyerere-Usagara, April 7, 2010

person may contact healers who tell the person he or she will only be cured by releasing the disease into the environment for others to be infected. It is common to see pieces of broken pots, broken coconut shells, and red and black clothes at crossroads, suggesting that harming or curative interventions have been conducted there.

Scavenged Elements of Healing Practice

While games and sports are primarily to entertain, they carry within them the use of magical medicine that can have harming effects upon opponents. In recognition of this possibility, teams, like dancing groups, prepare with victorious and protective medicine (*nk'hago*). This preparation involves tracking and collecting any materials from an opponent that were dropped in the environment that can be used to make medicine and thus render the opponent incompetent. Rendering an opponent ineffective (whether in soccer or traditional dances) involves picking sand from a site where the targeted individual has stepped. The collected sand is taken to a traditional healer who processes it to weaken the opponent or to make him develop an illness or a loss of motivation to compete.

Thus we see that the environment is a risky place for anything that is discarded, as it may be used for imprecatory intervention. A healer and song composer, Nhumbu Bumila, explained that he was afflicted while preparing for a dancing competition. Some of his spit had remained on sugarcane that was subsequently taken, without his knowledge, for use against him. The intention of his rival was to make Bumila too sick to

perform.³⁵³ Bumila noted that, while performing, he started to feel such a severe headache that he almost quit. He consulted his father in medicine about the problem and after divination he was told that the headache was an intended affliction aimed at rendering him less effective so that he would lose the competition.

APPLICATION, ACCESS AND AVAILABILITY OF MEDICINAL FLORA AND FAUNA

Accessibility, affordability, availability, and adaptability of medicinal resources, or “a” factors, influence the production, distribution and consumption of traditional medicines (Anyinam, 1987). Processes of environmental degradation, on the one hand, and conservation programs, on the other, create specific constraints and opportunities that shape these “a” factors. Land

use and land cover changes happening in Tanzanian landscapes are causing the decline of medicinal plant and animal resources and are forcing healers to travel longer and



Figure 33: Converted forest into farmland

longer distances to procure materials. In interviews and observations, healers noted that places that were covered by trees in the past have become deserts (*maporu galeela*), due

³⁵³ Interview and Song, Nhumbu Bumila, Kisesa, July 22-24, 2007,

to deforestation. A healer who has lived for many years at Kisesa (about 15 km from Mwanza city) noted that, until the 1980s, natural vegetation and large trees covered the Nyamhongoro Mountains in the area.³⁵⁴ However, these ecosystems have been transformed for agricultural use (Figure 33). Few trees remain; crops such as cassava have replaced trees in some areas. Sparsely planted mango trees have occupied others. The conflicts that are emerging now are over land that was initially communal, but is now owned by people who have transformed the land into private residential or farm spaces. This change of ownership restricts access for medicinal collectors, seekers of building materials such as thatches and wooden poles, and livestock keepers. One healer, Musamu Magulu, attributes these changes to increased population density, expansion of residential areas, and increased demand for firewood and charcoal. Of course, divergent views exist in the community about cultivation as progress, or as a distressing loss of open space that provides use of land for fodder and firewood (Fairhead and Leach, 1996). Despite measures to protect forests, the rate of deforestation has yet to be controlled in Mwanza. In many parts of Tanzania, timber resources remain the major source of energy, particularly charcoal and firewood (Persha and Blomley, 2009). Sukumaland has not been spared; the majority of its population depends on wood resources for energy and construction materials. Land clearance for farms, settlements, and development projects further exacerbates the destruction of the medicinal flora and fauna base.

Those areas that were communally owned are now privately owned or held by the state. One of the interviewed healers observed that it is now very rare to see healers with their assistants going to the forest to collect medicine, as was done in the past. He noted,

³⁵⁴ Interview, Musamu Magulu, Kisabo_Magu, June 28, 2006

“*Ukionekana utashikwa* (if you are seen you will be arrested). What helps is the availability of these medicines in the markets.”³⁵⁵ Therefore, questions arise. Where do healers procure medicinal resources sold in the market? What happens when these medicinal resources are not available in the market? How can healers sustain their medical services when they cannot access medicinal resources? Healers described their challenges to access medicinal resources. As one of them noted, “[Government] forest-keepers (men in this case) are aggressive like buffalos (*mabwana miti wako mbogo*).” In other words, government forest officials are not sympathetic to healers when they look for medicinal flora.

Therefore, healers who travel long distances are still not guaranteed easy access to medicinal flora and fauna, whether due to increased restrictions imposed by those who own land and forests or by practices imposed by the government to protect forest resources. This combination of economic, ecological, and property-related changes has confined healers in new ways, and is creating new discourses among them. Many of these discourses converge with conservationist positions and posit healers as environmental experts who should have privileged access to particular resources. For the majority of healers, however, what is important is a place where they are able to obtain medicine freely, or at a reasonable cost. As a healer in Kisabo in Magu noted:

The disappearance of medicinal plants and the long distances travelled to access medicine is forcing us to purchase these medicines from *gulio* (the flea markets). There are localities that were mentioned more often by healers as places where medicine could still be obtained. Areas that were mentioned more often as strong base for medicinal flora include Ng’weri (Geita and Sengerama districts in Mwanza), Tabora and Shinyanga. But it is expensive travelling to those places

³⁵⁵ Interview, Maje Jame, Hinda-Lugeye Magu; May 8, 2010.

and it costs about TSH. 50,000 to go to Tabora. You can travel but you also need a permit.³⁵⁶

Even more complex than access to plants and open land is the use of animal parts in traditional medicine. Obtaining animal parts used for medical purposes is a challenge because of declining animal populations and the resulting national and international regulations protecting particular species through trade and hunting restrictions. Today, many healers fear punishment for killing animals and/or possessing animal parts that are used in therapies. The existing hunting legislation in Tanzania favors tourist hunters and, to large extent, alienates and marginalizes local community members in the hunting industry (Majamba, 2001). Masilingi (1996) notes that walking and the use of weapons such as spears, arrows, and bows are restricted in national parks. These are the means local people use to hunt.

These bureaucratic norms and practical restrictions have proliferated, even as demands for medical and health care services have increased due to the growing magnitude of HIV/AIDS, pollution-related illnesses, and other communicable diseases (Nyika, 2007; Peltzer et al. 2008). These conflicting interests create management challenges that can both jeopardize conservation efforts and restrict people's ability to manage their livelihoods. For these reasons, consideration of healers as constructive voices within conservation practice is crucial. As we have seen in previous chapters, healers can capitalize on significant legitimacy and authority within rural communities

³⁵⁶ Interview, Musamu Magulu, Bulinda Villages –Magu, February 8, 2010.

and can serve as key informants about particular forms of stress and conflict that drive rural and urban populations to exhaustive use of resource bases.

Traditional healers interact with both patients and the environment on a daily basis in their medicinal practices. Therefore, healers are well positioned to observe and articulate ongoing environmental changes and to reflect on its cultural expressions. Like social scientists, healers are aware of the way in which the medicinal base is compromised by poverty and energy demand in rural areas. The rural poor are caught within, exhausting their resources in ways that belie a structural solution to their poverty. As one healer noted, “People cut down trees because of energy demand for firewood and charcoal. You know it is not good to cut trees, because they are the ones providing medicines. Every plant has medicinal properties. Therefore we are destroying the environment because of poverty.”³⁵⁷ The natural environment provides different kinds of ecological services, and consumers of those services blame one another depending on the resources they want. Livestock keepers blame farmers for converting land into farms. Farmers blame livestock keepers for intrusion of livestock onto farms. Collectors of medicine blame farmers and seekers of firewood and charcoal for destroying the medicinal medicinal base.

MORAL AND MARKETING GEOGRAPHY OF ACCESS AND ACTIVATION OF MEDICINAL RESOURCES

Nyamiti or herbalists, comprise a group of healers with knowledge of medicinal plants and their functions used to treat different conditions. Healers use different parts of

³⁵⁷ Interview, Lunde Webeya, Nyamatala-Magu, August 8, 2010

plants in different therapeutic activities including bark, leaves, roots, flowers and sap. There are many plants used in this field, including *ngeng'wambula* (*Entada abyssinica*), *nsaguneda* (*Euclea sp.*), and *lonzwe* (*Euphorbia sp.*). In one encounter, a healer attended a three-year-old in-patient child suffering from *mchango/nzoka* (literally intestinal snake or worm). The healer prescribed *ng'watya/mkalya* (*Zanha africana*).³⁵⁸ Although a majority of plants are used as actual ingredients in medicine, some plants are used for divination. Clients with undiagnosed problems are given a piece of *mnyaa* and are asked to put it under a pillow at bedtime. Healers say the *mnyaa* records clients' ailments or troubles. The client takes the piece back to the healer; before giving it, the client is asked *kukitemea* (to spit) on it and hand it to the healer for divination.

A healer interviewed in Mwanza describes how trees are valued in terms of ecosystem services obtained from forests:

Trees are a treasury, because people used it as a source of medicine. I am seeing now that every plant has its value; in the past we used some specific species such as *misubata* (*Diopyros fischeri*), *milojaminzi* (*Combretum fragrans*), *mibondo*, *mitundwa* (*Ximenia caffra*); we were selective in the past harvesting particular plants based on their functions, which is different from today's situation in which every plant is cut and harvested.³⁵⁹

The increased use of different plants is influenced by many factors. Healers gain knowledge of new medicinal plants through interactions with individuals from different ethnic groups with different types of plant knowledge. Some plant materials are used in desperation to treat different conditions that have not responded to the known medicine.

³⁵⁸ Interview, Mano Yenze, Mino ang'ombe, Masallo Ndagalu; July 24, 2010.

³⁵⁹ Interview, Lulija Lukulu, Nyamatata-Lugeye, Magu, August 3, 2010.

The disappearance of some species known to treat specific conditions has caused healers to substitute other species.

Sukuma healers categorize different plants based upon their importance in the field of traditional medicine. Each plant has intrinsic value, depending upon its application in the medical field. For instance, some medicines act as potent substances; others are used as additives or catalysts. Some plants are used to improve characteristics of the medicine, such as taste, color, and texture. Sukuma people have given names to some plants based on their role in therapeutic activities. For instance, one commonly used medicine to treat exposure to toxic materials is known as *ngw'ehunge*, functioning as *shihunge pye shabobi* (literally “protect us from all things that are bad”). *Ng'wehunge* is also prescribed for abdominal pains and for individuals who may have been poisoned. Many other plants

have been labeled based upon their medicinal-chemical compositions, and others based upon their symbolic functions. A plant like *Ng'wicha* (*Kigelia africana*) is used



Figure 34: Mushroom growing on a trunk

to prepare a concoction fed to

mothers to increase their breastfeeding ability. Its common name literally means, “increased secretion capacity.” The plant is also known and widely used to increase blood levels for anemic people.

A plant that germinates in another plant, such as a mushroom on a tree, has a logical use in the field of traditional medicine. The symbiotic or parasitic nature of these

plants defines their role in treating specific conditions. A healer in Butimba Mwanza described the use of a mushroom growing on a trunk (Figure 34). He noted that the mushroom is harvested and burned in a clay pot. The burnt material is ground and used to treat *masisa* (rashes) for children.

Some plants have multiple uses in Sukuma fields of traditional medicine, while others are widely known for their ritualistic activities. A healer in Kanyerere, referring to his own experience when initiated, noted that a plant like *mkola* (*Afzelia quanzensis*) is widely used in rituals and therapeutic activities, confirming results of other studies (Hinkkanen, 2009). In addition, the *mkola* tree is used to make equipment employed in the field of traditional medicine, such as *vigoda* (stools) for chiefs and traditional healers.³⁶⁰ The tree is also used for charm medicines and for construction activities. A healer in Mwanza noted, however, that the medical role of *mkola* (*Markhamia obstusifolia* or *Afzelia quanzensis*) is to treat leg swellings, abdominal problems, and pneumonia. Some other studies have shown the use of *mkola* in charms related medicine (Dery, Ofsynia et al. 1999).

Mubi Makemo, was interviewed and observed in Kanyerere-Misungwi while being initiated. He revealed details of the procurement and processing of such important plants:

We are processing *mkola* here; we were not able to find it in Bariadi. That location is in another region, Shinyanga, that was visited to find medicine, but this particular species could not be obtained there. But, we asked our neighbor in his compound and he allowed us to dig some roots and he gave us some milk *kufuha* (to bless) and we left some money at the spot where we harvested. That is why we left early in the morning, during sunrise, to go and harvest it while singing, “*Nasene ng’hwi ja mibanga ndi haya kuitwimila munanhungo, buli*

³⁶⁰ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

nasene ng'whi okung'wa Nhindilo na Ng'lewelo” (‘I should collect firewood of the *mibanga* (*Afrormosia angolensis*), I need to use them in a pot, and genuinely I should collect firewood, as a son of Nhidilo and Ng'lewelo’).³⁶¹

Healers use a set of standard operating procedures to harvest medicinal plants to ensure they're potent for the condition to be treated. Therefore, each plant, based on its function, involves specific rituals when harvested. These procedures involve different aspects, such as time of harvesting, tools to be used, persons involved, songs and prayers required, and methods involved in processing, storing and administering. In an excerpt from an interview with Makemo, he revealed that, for a plant like *Mkola*, rituals such as offering money and prayers to ancestors were necessary.

In addition, the harvesting has to be done early in the morning, during sunrise. Makemo also explained there is an important song used for rituals while collecting medicine to ensure effective harvesting. The song praises the ancestors by mentioning their names, and it elicits their approval. The medicinal plants in this song referred to firewood; however, these plants are kept and boiled in pots in order to release the curative energy of the herbs as this “fire.” Makemo further noted medicine is obtained from leaves, bark, and roots, but the majority comes from roots. Harvesting the *mkola* plant involves *kufuha* milk (the process of spitting milk to seek blessing from ancestors) for medicinal plants before harvesting. There are other plants that require the use of blood from animals, such as goats, for harvest rituals. Makemo related the exercise that comprised collecting and processing medicine for his initiation:

³⁶¹ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

When you are done harvesting that is when you start processing it by grinding it until it is softened; then you dry it; but if by any chance there will be rain while in the process of collecting; then that medicine is ruined and it cannot be used; you need to harvest fresh medicine.³⁶²

In the morning when at sunrise, that is when we go out to harvest medicine, we do not harvest medicine at night; there is no problem at all of collecting medicine during daytime. People normally do not come close to us in such a situation, because there are rituals that are undertaken before starting the exercise of harvesting medicine. People know not to interfere unless they have been invited or we have called them.

Because there are plants that require ritual procedures, such as offering goats and praying to the Lord so that he can offer the blessing that is when you start harvesting. We normally *fuha* (seeking approval and blessing from ancestors), the procedure that involves spitting fresh milk or water mixed with sorghum flour on the plant to be harvested, and we request the blessing from our ancestors who used such plants by mentioning their names. That is when we proceed with harvesting.”³⁶³

For many healers, places and procedures involved in collecting medicines are essential to determine the potency of medicine. For instance, the collected medicine is not supposed to be taken home before being prepared:

We do it here and we call this place a sacred place; the place that our ancestors used to do similar functions (i.e., processing medicine) that we are doing here today. These grinding stones (*mazunzu*) were used by our ancestors to mill grains in their era (Figures 35 and 36). These *mazunzu* have existed for many thousands of years and they signify that these settlements were here. That is why whenever we have a task like what we are doing today we are supposed to locate places like these; that we are not ignoring traditions. Without doing that, our medicine won't have blessings from our



Figure 35: Millstone (Zunzu)

³⁶² Interview, Mubi Makemo, Kanyerere, September 3, 2009.

³⁶³ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

ancestors to treat people if we do not involve them (preparing medicine in places they settled and using equipment they used in the past); we normally divide the medicine we process into small portions in order to simplify the work by involving many people.

But it is not only like that, every individual is blessed differently, *kila mkono wa mtu una baraka zake* ('each participant's hand has its own luck and will contribute differently in the medicine we are preparing'). For instance, there are people coming here from wealthy families; others from healers' families; others from chiefs' families; others from big families; others from people owning livestock. Therefore, all those *baraka* (blessings) are transmitted into our medicine making the medicine effective in different functions. It is blessed medicine, because every individual participating has been prepared and accepted by the ancestors. They (participants) were prepared by undergoing specific rituals before we started our journey and fulfilled the required conditions without breaking any of them until today.³⁶⁴



Figure 36: Processing medicine on a millstone

Rituals done before the exercise were to limit the bad traits and maximize the good traits of the participating members so that they would make potent medicine for its intended use. Makelemo continued, explaining the remaining tasks: “After processing the medicine, all of it will be collected and placed in one large *zunzu* (large millstone).” The medicines will be mixed with *shingila*, an important category of medicinal ingredients used as additives that do not limit or can even enhance the potency of medicine. *Shingila* includes honey and other ingredients that are kept secret (Cory, 1949). As in biomedical or culinary fields, healers are aware of the importance of keeping their specific recipes or formulas unknown, because this differentiates the expertise of healers:

³⁶⁴ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

After finishing mixing the medicine, instructions follow on how to use the medicine, as everybody here will be given it. The exercise to distribute the medicine will start; I will first be given a large portion of the collected medicine, because I am the person undergoing initiation. The next will be my father (the father of medicine, Sefu Dosele), who is the in charge of the entire exercise, then other participating members will follow and they will receive equal amounts of the remaining medicine.³⁶⁵ When we are done, and the exercise of distributing medicine is over, you will see that we will make a line, a single file line (Figure 16), then I (Musobi Basondole) will be in front and others will follow. The last in line will be my father (Baba Sefu, father of medicine); in this line nobody is allowed to pass through (*kuingia kati*) and if it happens that the line has been broken by people passing through it, then all the people at the back (where crossing was made) will be forced to throw away the medicine they carry.

The medicine is considered bad and it should be thrown away, because when a person interferes *atakuwa ameikata dawa na kumaliza nguvu* ('he would have ruined/adulterated the medicine and it will lose its strength and efficacy'); and perhaps that individual has *nuksi* (bad luck/mischief) that will destroy the medicine. We are, therefore, very careful and take all necessary measures when



Figure 37: Single-file line of the team carrying medicine, a line that should not be crossed

collecting and processing medicine. Or if it happens that you are late and you arrive home at the time when cows are *machungani* (out grazing), then you must sleep outside until the next day; if you disobey these rules then you might cause a disaster (*madhara makubwa kwenye mji*) at your house, your properties and belongings. That is why we obey the voices from our ancestors when they tell us what to do, at what time, and what we shouldn't be doing.

Makemo continued, noting, "Traditional medicines have important rules and every participating individual is obliged to follow, because these medicines have

³⁶⁵ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

miracles; these medicines may cause someone to disappear!”³⁶⁶ This statement suggests that, even though medicines are made to heal, cure and treat, they can also be dangerous if their rules are not followed. Different procedures used to initiate healers bring ideas for discussion concerning whether actors for traditional medicines have to qualify based upon set procedures. Often, traditional healing practices are challenged through the biomedical lens for a lack of standards. But, as Nick Reo has argued regarding the informal moral and ethical codes that govern hunting practices among Ojibwe tribes in Wisconsin and Michigan, the initiation of a healer seems to follow a logical pattern and obeys a certain set of rules and operating procedures that could be characterized as standards of its own (Reo and Whyte, 2011)

GEOGRAPHIES OF MEDICINAL PLANTS: SACRED AND PRODUCTIVE SPACE OF MEDICINAL RESOURCES

Interviewed healers noted there is a correlation between the strength of medicines and the geographical spaces where they are obtained. Each plant has its favorable environment in which to grow and produce particular medicinal compounds. The selection of the source of medicinal resources among healers depends on different factors, including healers’ familiarity with the geographies of medicinal flora and fauna. The majority of healers select their settlements based on farming activities, livestock keeping and the availability of and accessibility to medicinal resources. The presence of many customers was not a significant determining factor for healers in selecting their

³⁶⁶ Interview, Mubi Makemo, Kanyerere, September 3, 2009.

settlements, and was particularly insignificant for healers residing in rural areas. However, field observations indicate that healers are increasingly opting to establish their settlements in areas with sufficient customers, and many are moving their operations into urban centers.

Strength of Medicine: Mountain vs. Lowland and East vs. West

A healer differentiated the strength of medicines obtained in mountains from those obtained in lowlands by noting, “Plants obtained from the mountains are more effective compared to the herbs obtained in lowland areas (*tambarare*).” When asked about the discrepancy he said, “People do not farm in the mountains, thus there is a possibility the land there is fertile with more nutrients, however, each species has its ecological area that can be found.”³⁶⁷

Another healer who was in the process of initiation in Kanyelele (Misungwi district) in Mwanza differentiated between the strength of medicine from the East or West, while emphasizing the correlation between the origin of his ancestors and the power of the medicine:

We trust medicine that is obtained from *Shashi* (East), we trust this medicine to be effective when compared to the medicine obtained from *Ng'weli* (West) including places such as Sengerema and Geita; that is why we collected our medicine from there (*Shashi*). These are very effective medicines for different ailments; they do not fail. The medicines from the East are more effective, because ancestors from the East are stronger than ancestors from the West. That is why we decided to collect our medicine from the East. If we couldn't find some specific medicine that is when we would consider going West.³⁶⁸

³⁶⁷ Interview, Simo Rashi born in 1947, Sanungu Village- Lugeye, Magu, August 7, 2010.

³⁶⁸ Interview, Mubi Makemo, Kanyerere, September 3, 2009. (The above quote reveals one of the isolated cases among Sukuma healers and the knowledge of the power of medicine based on the direction (East or West).

Maasai healers operating in Mwanza have different opinions, and have continued to embrace the widely accepted notion among community members that medicine from Maasailand (situated in Northeast Tanzania) is better than medicine obtained from other regions in Tanzania. One piece of evidence to explain the greater trust given to Maasai medicine is the herb named *masai* or *kasuku* (*Warbugia ugandensis*), used in different therapies for various medicinal characteristics to treat many conditions. The *masai* or *kasuku* herb is popularly sold in the market in Mwanza, and Sukuma healers use it often in the preparation of therapies. Maasai healers also use the herb in most of their medicinal mixtures due to its purportedly therapeutic activity that treats many conditions.

Maasai healers are aware that herbs can be obtained in Mwanza, but these are not effective. Therefore, they must travel to their native land in Arusha, as one of them revealed:

I travelled to Arusha two times last year (in 2009) to collect medicine, and people who know medicine in Arusha bring them into the market, and it makes it easy for us to buy from them. What is different between here (in Mwanza) and Arusha is that healers have been allocated sites in the large market in Arusha for them to sell and practice medicine at reasonable prices. Concoctions are prepared right there; and clients consume the medicines right there.”

He compared the way healers operate between the two regions, noting, “Healers in Arusha have rooms to practice medicine, that there is privacy and a secure place to keep medicine. The situation is contrary to what is happening in Mwanza where Maasai healers operate in open spaces and they use umbrellas as their only shelters.” He also noted that medicine could be obtained in abundance in Arusha, and that the challenge is how to transport it to places like Mwanza. He observed, “Bringing medicine to Mwanza from Arusha involves packaging medicine in sacks that are then transported by buses

costing between 10,000 and 15,000 for each sack. In order to reduce the bulkiness and transportation cost, healers prefer to grind medicine before transporting it.”³⁶⁹

A Maasai Healer Challenges Sukuma healers: A Maasai healer noted that, in order to protect the trees, Maasai healers use only the bark. He was surprised by the deforestation happening in Sukumaland and suggested that Sukuma healers dig up the roots. “In Arusha (region where Maasai people are from) it is prohibited to dig up the roots, but in Mwanza people just dig up roots.” He also noted that elderly people protect medicinal resources in Arusha.³⁷⁰ However, field observation of Maasai healers showed tables with roots as well as bark.

Stressing the use of bark among Maasai healers suggests that they have decided to forgo the use of roots to improve the survival of trees. Other healers view protection of medicinal resources differently, however. One of them noted that, despite the existence of laws aimed at protecting medicinal resources, healers are required to take necessary measures to provide healing services. Another healer said, “It is important that we do not remove the entire plant (avoid uprooting). What we normally do is pick leaves, chop backs, and also dig some roots while ensuring, also, that there are enough roots remaining to sustain the plant for it to grow for future use. In other words, *ukataji huzingatia kesho* (today’s cutting should not compromise tomorrow’s demand).”³⁷¹ This argument is a replica of the sustainable development goals that promulgate ideas that the activities of today should not compromise the survival of future generations.

³⁶⁹ Interview, Oleluca Laze; Mwanza City; February 2, 2010.

³⁷⁰ Interview, Oleluca Laze, Mwanza City; February 2, 2010.

³⁷¹ Interview, Mdaha Hamo, Butimba-Mwanza; February 2, 2010.

RITUAL SITES: CONSERVATION THROUGH REVERATION OF RAIN SPECIALISTS

Sehemu za matambiko (ritual places) in Sukumaland have existed for many years, and, according to healers in Mwanza, they have served various purposes. They formed a cultural identity intrinsically linked to the environment through ideology and the practice of medicine. A healer in Mwanza noted, “They (ritual places) were places to appreciate and embrace values of things and space based on the beliefs developed in a community (*sehemu za matambiko ilikuwa ni namna ya kukipa kitu kipaumbele cha namna imani zilizojengeka kwa jamii*). Another healer noted that rituals were an important aspect in communities to strengthen social cohesion, although these rituals are now considered outdated.³⁷² Ritual sites that were revered in the past, including mountains, water wells, and trees, are now declining due to social and cultural transformations that are rapidly taking place in many societies. When asked if rituals were still practiced, and if ritual places still existed, a healer in Ndagalu Magu noted, “We have ritual places of our *bakurugenji, mashigo ga batale* (ancestors’ graveyards); we have them (ritual places) and we clean and maintain them.³⁷³

³⁷² Interview, Samsa Kamo, Butimba-Mwanza, February 11, 2010.

³⁷³ Interview, Robesi Chereni, Matale, Busunguku, Mbarika-Misungwi; March 16, 2010.

“Rituals are said to be disappearing since many people have neglected their traditions and are converting to Christianity and Islam, the religions that, to a large extent, have discouraged traditional ritual undertakings in Sukumaland.”³⁷⁴ Likewise, the

banning of divination has reduced the use and protection of ritual sites. Another healer echoed the view that new religions have changed beliefs about rituals: “There are not many rain specialists remaining. The major reason is religions; people have clung to religious beliefs. They



Figure 38: Protected forest at the grave of the rain specialist

see rain coming naturally; then why should they use medicine to bring rain.”³⁷⁵ Additionally, actors who participated in these rituals in the past are dying and the new generation is reluctant to learn and participate in them.

Ritual places were an important part of the identity of the community and were not only aimed at facilitating a specific task. Instead, rituals were more often about social structure and relationships to the physical landscape. The few remaining sites show how ritual places served different purposes. First, ritual spaces ensured the maintenance of cultural and spiritual values among community members. Second, they were the sites that remained as forest reserves for conserving biological processes (Figure 38). These sites

³⁷⁴ Interview, Sonia Fede, Kisesa, June 30, 2006.

³⁷⁵ Interview, Nhumbu Bumila; Kisesa-Magu; July 24, 2007.

embraced protection measures that used traditional knowledge systems. The grave of the rain specialist, Msobi Kiyungu, is one of the few remaining sites, in the Mwanza region, and the ritual still conducted at the grave reveals its usefulness in societies.

Few sites have remained that continue to honor rain specialists. One of those sites is the grave (Figure 39) of the rainmaker in Mwabomba-Misasi (Misungwi district in Mwanza). The late Msobi Kiyungu was a rainmaker and a *mwanangwa* (assistant to the chief). Rituals to honor the late Musobi Kiyungu are supposed to occur every



Figure 39: The grave of a rain specialist with a thatch shade

January, conducted primarily by family members (however the ritual was not conducted in 2010, the time when fieldwork for this study was conducted).

Under the thatch roof shading (Figure 39), bones of either cows or goats remain to recall feasts that took place during previous ritual ceremonies. The roof appears derelict; this is attributed to heavy rains reported this year (2010). The grave is situated at the centre of a small forest, which is preserved mainly for ritual purposes. Mr. Abel Zaga, a family member in Musobi's clan who was a tour guide during field observation, explained the significance of the site, noting the place receives many visitors each year – tourists and family members – who come for rituals and to maintain the site. Abel says that family members gather to clean the place every year. The path to the grave is cleared

to make it easy for visitors to see the grave of the rainmaker. One of the conditions to view the site is that visitors may not enter the gravesite while wearing shoes.

Narratives by Abel Zaga at Kaburi la Mgemi wa Mbura (at the Grave of the Rain

Specialist (Interview, April 13, 2010)

What are the procedures to honor rain specialists? “One of the conditions here is not to enter to this site while wearing shoes on our *mkurugenzi* (ancestor), because you are visiting to greet him and wearing shoes at the site is disrespectful to the ancestors, and is discouraged. It is similar to cultural beliefs that people were advised not to wear shoes when visiting graveyards, because that is disrespect to ancestors. But people are neglecting and abandoning these beliefs and taboos. People do not care anymore about the discipline required in places like this. It is similar to a person kneeling down when asked to bring something for Wasukuma people (girls are supposed to kneel down when greeting or offering things to their elders). If they do not do that they feel bad, and the same applies to the ancestors if procedures are not followed. They won’t be happy and they may resist offering their blessing and approval. Shoes are not allowed during that visit. Visitors are cautioned on their arrival that they should take off their shoes before visiting the grave. Comparatively this is one of the few remaining forest that are greenish, because of the protection.”

The disappearances of such environments not only have direct impacts on the healers’ activities; the loss of such sites reveals broader issues of livelihood, culture, climate change and environmental protection. The decline of such environments has effects on the society. This place is also threatened by the expansion of agricultural activities and the harvest of trees for firewood and construction. Stumps close to the grave show the effect of deforestation (Figure 40). The guide noted some community members want to expand their farmland; others are interested in harvesting trees.

When did this arrangement start? “This arrangement (of maintaining the grave) has existed for many years, we have grown seeing it, and we have inherited what they did in the past. This place was here when I was born and rituals have been done since then purposely to honor the rain

specialist. Therefore, this place is cleaned and protected. These ritual practices are done yearly in what is called *kulamyā chinichi* (honor ancestors). Similar practices are done at the grave of the father of this ancestor who is buried here. Even there to *Ukilinkingula wa kumyala* (to the parent of this person who is buried in this area), similar practices are done, and a forest over there is protected like what we are doing here.”

Who is managing this place? “All clan members manage this place even though we have our leaders called Musobi and Mwana Fung’ho; they are the supervisors of monitoring all activities in the area. There are *mafiga/gana* (cooking stones arranged in threes to support cooking pots) that are used to prepare meals during times of propitiatory offering (*matambiko*). Before New Year starts, clan members come and clean; renovations are also made to the shelter in order to welcome a new year with some blessings.”

Who was he? “He was a rain specialist; he was a leader; he was a *mwanangwa* (an assistant to the chief) of this area. There have been people keeping that record, and the people who live in this area are all relatives. Mwana Fung’o lives in the neighborhood and is mandated to protect this area. But grandchildren also visit this place regularly. That is why there are not many trees remaining. This area was supposed to have been covered by trees – good trees; they have been cut. It was not like this (with portions of land converted into farms, trees being cut and people living in the neighborhood), and that is why you will just see stumps. There used to be really big trees. We do this to honor our great ancestor (at the grave). His father, who was also a rain specialist, is buried at a distant place but similar procedures are done like what we do here. He was also a rain specialist, and from his expertise he taught his children. He taught them how to harvest rain as well as duties of *uanangwa* (being assistant to the chief).”

When he was alive can we say that there were no problems with rain? “In this area there was not a problem because whenever there was a problem like a rain shortage, chiefs and their subordinates (*wanangwa*) consulted rainmakers like the (deceased) one here, and they went *kugema mbula* (to harvest rain), by making use of their medicine.”

What were the payments to these rain specialists after they have performed their tasks? “Payment and compensation were made through food; people in the village brought food such as grains; any food that was available. Rain specialists found themselves filling all their equipment with food since many people came and brought food; other people arrived from distant places such as Buhungukila (Ngw’eri known as Geita and Sengerema). Others brought *ngere jabo* (storage facilities) that they owned.”

What happened to the trees that were here? “They were big and tall trees around here. It was a forest and only a small area has remained. All this area belongs to Musobi only even these houses seen in the area. There were plenty of trees and people were disciplined in the past, and there was no such *kuvamia na kukata ovyo ovyo* (desperate encroachment and haphazard cutting). You will see only stumps remaining, a clear indication that people have cut them. In the past they never encroached, but this generation of today lacks discipline. In that corn farm it was full of trees; there were trees when I was growing up. It all belonged to Musobi and people are now cutting trees to expand farmland. People are cutting trees in order to grow food and that is why there is a small, protected area remaining *ahishigo* (at the grave). It is only the gravesite that is protected. Trees that were here are gone. Initially, protection covered a large area, but it has diminished over the years.

Were there plants with medicinal values and do they still exist? “Yes there are medicinal plants as you will see some native plants such as *gembe* (*Dalbergia melanoxylon*) that has disappeared in many other places. But it is still here if you look for it. There is also *mimale* (*Lonchocarpus capassa*)

mikoma is also available as it can be seen, but it is also disappearing in other places. You will see trees like *mkoma*. *Miyuguyu* (*Balanites aegyptiaca*) is also available, like this one you see and it is very useful in the field of traditional medicine. For instance *nyuguyu* (singular for *miyuguyu*) has been ethnobotanically studied and proven to have antifungal



Figure 40: Stump at the grave

effect (Hamza et al. 2006). Some of the common plants species that can be observed include *magaka* (*Aloe vera*), which has medicinal significance. There are many other foreign trees; they are not native to this area, such as *mihale* (*Acacia nilotica*). *Mhale* (singular for *mihale*) is used by Sukuma people to treat several illnesses.”

PROBLEMS ACCESSING MEDICINAL PLANTS

There has been a dramatic decrease in the abundance of many important medicinal plant species as their habitats are lost through deforestation, cultivation,

overgrazing, burning, droughts, and desertification (Homsy et al, 1999), which is exacerbated by unmanaged local and international demand for medicinal plants (Naur, 2004). These are issues underlying the complexity of the medical practices in Mwanza. Access to medicinal plants is emerging as one of the challenges to healers, due to the decline of medicinal plants and the privatization of land where medicines exist. Different actors in Sub-Saharan Africa are competing for land and land resources; this condition has created a wide range of conflicts and violence. The conflicts happening in the region, according to Peters, are a result of two forces: preoccupations about land and contests over political powers (Peters, 2004). Traditional governing systems for land were destroyed by the colonial rulers who created new territories and sovereignty based on their own interests. Colonial rulers, according to Peters, disrupted the direct relationship that existed between humans and the land by restricting ritual roles that extended to rainmaking and land maintenance. Spurred by the interest in feeding their own markets with agricultural products produced in colonies, colonial rulers pushed for an agricultural development agenda that entailed resettling people and also creating new ways of farming in what is characterized as “modern farming.”

After colonialism, the independent government, in its effort to develop and achieve a modern society, re-emphasized the need to resettle people. The resettlement programs, as covered in the Ujamaa villagization chapter, created conflicts over land ownerships that had cascading effects for healers. Tensions over land still exist. Some people lost their land, then hosts contested new land that these people occupied in the 1970s during resettlement programs. The increase in population is another factor that has contributed to the conflict over land. The gap between rich and poor has dramatically

increased. Rich people are more likely to use money to expand their territories, even by taking land that was communally owned, and thus restrict access to local inhabitants, including healers.

Population growth and energy demand as drivers for medicinal-plant loss

Healers, like any other actors, are aware that the environment is damaged, as illustrated through their narratives. “This environmental destruction is caused by population increase and poor economic conditions, as people are forced to cut trees and burn charcoal for energy and as a means to sustain subsistence living; but that is how we destroy ourselves.”³⁷⁶ Expanding land for farming, increasing urbanization, and poor practices in mining activities have also contributed to deforestation and the cutting of trees in habitats where medicinal flora exist. Some specific plants used for therapies are hard to obtain due to droughts, overgrazing, and the expansion of farmlands and urban areas, in addition to the private ownership of land.

Healers in Mwanza, for instance, note that environmental damage became a more salient feature after the Ujamaa villages that were established in the late 1960s and the early 1970s (Kikula, 1996). This was the time when people started using charcoal. People began cutting trees haphazardly, without planting or replacing trees they had cut.³⁷⁷ This situation has been attributed to a number of factors, including reduced use of animal dung due to reduced capabilities to manage livestock that were the source of energy.

³⁷⁶ Interview, Nyangi Yama, Sanungu Lugeye Village- Magu; June 8, 2010.

³⁷⁷ Interview, Masa Buba, Lugeye A - Magu, May 10, 2010.

Healers also indicated the way in which technology in their communities has affected the environment. They cite the role of axes and fire in deforestation and desertification. “When we arrived here it was a dense forest (*mapori makubwa*), but it is the axe and fire that have made plants extinct.”³⁷⁸ Healers noted that societies have changed. There is more environmental destruction now because people have ignored traditional beliefs governing the protection of plants. One healer explicitly explained, “The destruction of the environment and cutting of trees is happening nowadays and is a serious problem; we were scared to cut trees haphazardly in the past; it was a



Figure 41: Digging and cutting medicinal plants

mwiko (restricted by taboos) to cut trees *ovyoo* (haphazardly); but it is what is normal nowadays (Figure 41). This has caused a lot of problems, such as increased costs of traditional medicine.”³⁷⁹

Causes for the loss of medicinal plants

The selling of medicinal plants in the market has emerged as a lucrative business. In a situation like this, healers are directly and indirectly damaging the medicinal base. Healers acknowledged that their peers, who are suppliers of medicinal flora and fauna, are causing irreversible change. However, healers see themselves as having a role in the

³⁷⁸ Interview, Manga Kasongole, Mionang’ombe Ndagalu, July 28, 2010.

³⁷⁹ Interview, Gamala Lunga, Ngamigamba Busumabu, May 25, 2010.

conservation of medicinal resources. They, too, are worried about people who haphazardly harvest medicinal plants. Healers and non-healers alike are said to ruin the medicinal base; they exploit all plants known to have medicinal use and sell them at the market. This kind of uncontrolled harvesting of medicinal plants neglects procedures that will ensure the sustainability of plants in the forest and other areas where they are obtained. Healers feel that non-healers contribute to the destruction because they do not consider the future. Non-healers do not have the knowledge that plants speak and listen, and that they require sensible treatment. One respondent noted that the loss of medicinal plants is caused by *matapeli* (impostors/con men) who would sell anything. He noted these *matapeli* are digging up plants haphazardly in order to sell them at the market.³⁸⁰

Healers vs. non-healers: Who is destructive?

Healers claim they are not destructive because they are aware of the importance of protecting the plant base, unlike their counterpart non-healers. A healer, responding to questions about procedures used to harvest medicinal plants, replied:

There are procedures that have to be followed when harvesting medicinal plants. I do not buy medicine in the market, but I go by myself to collect them, because each plant has its own procedures when extracting roots and we are required to pray, because the tree hears our prayers.

It is hard to grow medicinal plants, as one of the respondents was quoted, saying, “*Msenene (Xylopiya odoratissima)* has no seeds.”³⁸¹ Another healer stated, “People who are creating all these problems destroying the base are these *wagalu* (literally

³⁸⁰ Interview, Maja Jame, Hinda-Lugeye Magu; May 8, 2010.

³⁸¹ Interview, Maja Jame, Hinda-Lugeye Magu; May 8, 2010

representing a dancing group in Sukuma but is used here to denote sly people), and they have these behaviors of uprooting the entire plant and removing all of its roots. I do not know why they do that to remove the entire plant”³⁸² For him, harvesting of medicine should not threaten survival or regeneration of the plant for future use. Another healer did not consider himself destructive by harvesting medicine from small plants. He said, “I do not have plants that I have planted by myself, but I do not harvest from big trees to destroy them. I just harvest from small plants.”³⁸³ However, destruction is not differentiated based on the size of plants, because the plant might be small but fall into the category of endangered or threatened species. The availability of medicinal resources in the markets subjects sellers to the accusation that they are the one who destroy the environment and cause the extinction of medicinal plants. One respondent noted, “There are those individuals selling medicine in the markets, they are destroying the environment; we are trying to prevent that condition and plant trees in nearby places.”³⁸⁴

As seen here, state control through the establishment of Ujamaa settlements has been replicated in other sectors. For instance, the Ujamaa villagization exercise was concurrent with biomedicalization of the health care system in Tanzania. Likewise, new systems are developed regularly for environmental governance in which priority is given to external investors for the extraction of national resources for non-locals. In most cases, local people see the related legislation to access resources as cumbersome. In responding to the challenges they encounter in accessing medicinal plants, healers have adapted different strategies that involve travelling long distances, planting their own plants,

³⁸² Interview, Masa Buba, Lugeye A-Magu; May 10, 2010

³⁸³ Interview, Petela Buli, Kawe Kamo- Ng’wamanga-Magu; August 8, 2010.

³⁸⁴ Interview, Sonia Fede, Kisesa- Mwanza, June 30, 2006

buying medicinal plants from the market, and asking clients to bring specific plants that they can use to make medicine. The discussion of these aspects is covered in the next section.

ADAPTIVE STRATEGIES BY HEALERS: ACCESSING MEDICINAL PLANTS

Healers have different means of obtaining medicinal flora and fauna used to make various therapies. Healers noted that there are different places where medicines are obtained, such as harvesting planted or natural medicinal plants on their own land. Others have to travel to different places in order to secure medicines. Still others noted that they have to rely on their dreams to direct them to specific medicines,³⁸⁵ and many others say they buy herbs in the markets. Healers are now obliged to alter their processes in order to respond to the changing environmental landscape as well as the national and international policies instituted regarding access to ritual places and medicinal resources. International research interest in traditional medicine has grown significantly, parallel to the consumption of alternative therapies worldwide (APSSSAM, 1994). The International Conservation Union of Nature (IUCN) reports that the use of traditional ecological knowledge for natural resources management has been undervalued (Berkes, 1999). Likewise, traditional healers are generally inadequately represented in research concerning their roles in resource management and environmental governance. Concern over environmental degradation has made healers' ritual spaces and medicinal resources increasingly subject to conservation measures. Some healers attribute the challenges of

³⁸⁵ Interview, Petela Buli, Kawe Kamo- Ng'wamanga-Magu; August 8, 2010.

accessing medicinal plants to government intervention: “We request that the government create strategies to prevent environmental destruction and loss of medicinal plants”³⁸⁶

Different practices used to collect, process, and distribute medicinal resources reveal the impact on traditional medicine from the environmental change/management programs in both local and international markets. In their search for medicinal resources, healers have had to adapt to new strategies in order to sustain their businesses. There are common plants that are increasingly used in Sukuma healing practices, such as *nungu gwa mapando* (*Asparagus falcatus*), said to treat many conditions, including peptic ulcers, abdominal pain, constipation, high blood pressure, and infertility among women. Others increasingly common plants are *miyuguyu* (*Balanites aegyptiaca*) and *Ng’otobalasi*.

Individual initiatives and planting trees

One healer noted, “People have started understanding the importance of trees and they have started planting them”³⁸⁷ Another said, “Generally it is difficult getting medicinal resources, because wild plants have been destroyed. We are taking initiatives to plant these medicinal plants.” Many healers have taken individual responsibility by planting trees in their neighborhood. “I have planted some *minengonengo* (*Securidaca longipedunculata*),”³⁸⁸ the herb used to treat conditions such as convulsion (AMREF, 2006). A representative of Huruma Traditional Medicine, situated in Mwanza city, noted that they have established gardens to grow the *muarobaini* (neem plant, *Azadirachta*

³⁸⁶ Gamala Lunga, Ngamigamba Busumabu, May 25, 2010.

³⁸⁷ Interview, Nyangi Yama, Sangungu Lugeye Village- Magu; June 8, 2010.

³⁸⁸ Interview, Masa Buba, Lugeye A - Magu, May 10, 2010.

indica), the most commonly used herb in their practices.³⁸⁹ Another healer noted, “I have grown some specific plants such as *ngemwa mbulwa* (*Entada abyssinica*), which treats conditions such as *safura* (hookworm) and *tegu* (tapeworm). The African Medical and Research Foundation indicates that *ngemwa mbula* is widely used to treat backache (AMREF, 2006). “Other plants are obtained in my farms, and I have told people not to cut them.”³⁹⁰ “Plants like *mihale/mdubilo* (*Acacia nilotica*) are a cure for *madonda ya koo* (tonsillitis). You dig them up, and you properly prepare the root, and it is an effective cure when taken as a drink, and it helps increase blood levels.”³⁹¹ Other methods used by healers to respond to the decline of medicinal resources are to use the herbs they have harvested efficiently, and to establish networks with other healers to share medicinal resources, as the narrative below illustrates:

When you come back you use them carefully, before they are finished you go again. For those plants that are in my areas, I create fences to protect them. In a situation where you receive a client and you do not have medicine, you need to allow him to go to other healers. There are plants that you will never find no matter what you do; but I request them from my colleagues (other healers), because we are different in our capabilities, and there is a possibility that they will have medicinal plants I need. There are plants that are hard to find, such as *kumvwa mbizo* (*Crosspter febrifunga*). I know one is there at Gusembile village, but people have harvested almost all of it. We healers we are not jealous (*tutabizaga ni lusubi lyose lyose*) and if you encounter others that have located a plant and are digging it up, you will just agree on how you can share what is there, particularly when you encounter an honest individual with a good heart (*‘ulo usanga uwa moyo wela’*) you exchange it to go and help people³⁹²

Adaptive strategy travelling to far places

³⁸⁹ Interview, Silisi Rwemu, Mwanza City, February 17, 2010

³⁹⁰ Interview, Arony Bukebe, Kisesa-Mwanza; October 3, 2009.

³⁹¹ Interview, Simo Rashi, Sanungu-Lugeye, Magu, August 7, 2010.

³⁹² Interview, Jomayo Mayoma, Matara-Sumbugu, Mbarika – Misungwi; March 20, 2010.

Travelling to far places is mentioned as one solution healers now use to secure medicinal resources. One healer related, “I cannot access medicinal resources here (near to his house) and I have to travel to other regions, namely Kahama in Shinyanga and Tabora, where there are still some medicinal plants.”³⁹³ Another healer, who had a dream about a plant he needed for treatment, noted, “More often I dream about plants and recently, I had a dream about a medicinal plant – *nsubata* (*Diospyros fischeri*) – which is not available in this area. I was forced to find it in other places, and I had to travel to Ndagalu (Magu) or Busumabu (Kwimba).”³⁹⁴ “I have some plants and I had to get others from places like Sengerema. I plant other trees, but there are trees that are hard to plant, such as *shela*.”³⁹⁵ Healers operating in urban areas, particularly those who come from regions other than Mwanza, see the problem of accessing medicinal resources in new territories as a challenge. They have to trace medicinal resources back to their native places, which becomes expensive. As a healer from Kigoma explained, “I am forced to travel to my place of birth (Kigoma the region in the West of Tanzania) where I am familiar with the environment; the place where I can obtain medicinal plants.”³⁹⁶ In their native territories, healers are able to gather specific medicines they need. Travel expenses among healers contribute to high prices for therapies offered by traditional healers. A majority of interviewed healers acknowledged that there were few places remaining where medicinal plants can be obtained. There were regions that were mentioned

³⁹³ Interview, Maja Jame, Hinda-Lugeye Magu; May 8, 2010.

³⁹⁴ Interview, Gamala Lungu, Ngamigamba Busumabu, May 25, 2010.

³⁹⁵ Interview, Robesi Chereni, Matale, Busunguku, Mbarika-Misungwi; March 16, 2010.

³⁹⁶ Interview, Rasha Jama, Butimba_Mwanza, February 9, 2010.

frequently as places where medicine could be obtained at a relatively low cost. These regions include Sengerema and Geita in Mwanza.³⁹⁷

Another healer, Mama Mwasena, from Tabora, had practiced medicine in Mwanza for about ten years. She explained, “Most of the medicine I am using here is obtained from Tabora. There are not enough trees in Mwanza. In Tabora, you will get these medicinal plants in the forest that is in between Tabora and Kigoma. I have tried planting some medicinal plants, but not all of them have survived. I have only two species that have survived.” Another healer noted, “Accessing some medicinal plants is a

problem and we must incur some costs, thus I sometimes buy them here but more often I travel to Shinyanga and Tabora. You will notice some medicines that are sold here in the amount of TSH. 3000 can be had at a lower price in Tabora in the amount of TSH. 1800” Another healer sees the Tabora region as a place where medicinal resources can still be obtained: “I go to Tabora about three times a year.”³⁹⁸



Figure 42: *Gulio* (Flea market) source of medicinal resources

Asking clients to make purchases at the market

On some other occasions, healers have to ask their clients to purchase and bring herbal ingredients back to them. Asking clients to bring ingredients allows healers to

³⁹⁷ Interview, Mbalama Salime, Nyamatala- Magu; April 8, 2010.

³⁹⁸ Interview, Mdaha Hamo, Butimba-Mwanza; February 2, 2010.

create stocks of ingredients used to prepare different therapies. Through this process, all the ingredients can quickly be obtained, allowing the healer to merely take the responsibility to mix a remedy according to the desired ratios, adding other ingredients that they can collect themselves.

Clearly the *gوليو* (flea markets) have served as a place where medicinal plants are obtained. These markets involve people who sell different things; mobile vendors sell medicinal products alongside other animal products. Local markets have adopted free trade policies. The lack of effective mechanisms to monitor what is offered creates conditions in which substandard products are sold in the market. Some healers who depend on these markets for the ingredients in their medicines are concerned, arguing that not all traders can be trusted. Healers are worried that they cannot know if medicines showcased in the market have been there for such long time that they has lost potency. This concern was echoed by one interviewed healer, “We get these medicines by purchasing them in flea markets, and these medicines more often are exposed to sunlight, dust, rain and sometimes they lose their strength; they expire because of long and poor storage.”³⁹⁹ The way in which different kinds of products are obtained shows the fragmentation and specialization of the traditional medicine market. Few healers have integrated practices that can secure different kinds of medicine on their own and then administer them to the clients. The selling of fake or expired traditional medicine parallels the way in which fake and substandard biomedicines have spread into the market, particularly in developing countries.

³⁹⁹ Interview, Sangela Ng’wela, Sali-Lugeye, Magu February 4, 2010.

The Government – Which Side? Healers’ Opinions

Healers have different opinions about the governmental support they receive for their practices and for the preservation of the environments within which medicinal flora and fauna are obtained. For instance, there are members of the healing profession who feel that the government is not doing enough. “The government is not taking responsibility, it does not value us, for it is not giving us a priority. It was a forest here in the past but you can see now how hard it is to get trees.”⁴⁰⁰ In some cases, the government is seen as unresponsive to initiatives by healers aimed at protecting medicinal flora and fauna. “The government is not concerned; it is not appreciating that we treat people and they recover. They (government agents) do not come to see what we are doing to treat conditions that the biomedical institutions cannot.”⁴⁰¹

One herbalist respondent is worried about the way in which healers are abandoning the practice of medicine, as well as the damage to the medicinal plant base. He wants the government to reverse the damage, “Everybody is aware that environmental destruction is a big problem. Though there are other healers offering some medicine, they are giving up now. I am frustrated with this situation and I want the government to take the necessary measures to deal with people who are destroying the environment.”⁴⁰² Some healers put blame on current government officials and lament the death of the former president, Mwalimu Julius Nyerere, whom they think cared more about protecting forest resources, “I am disappointed with the leaders, because they are not concerned with the ongoing destruction (*Mimi nalia na viongozi hawajali kabisa kwa uharibifu*

⁴⁰⁰ Interview, Mano Yenze, Mino ang’ombe, Masallo Ndagalu; July 24, 2010.

⁴⁰¹ Interview, Mbalama Salime, Nyamatala- Magu; April 8, 2010.

⁴⁰² Interview, Makonge Lyakula, Lugeye A-Magu, August 6, 2010.

unaoendelea). Nyerere (the former president) was different; he prohibited cutting trees haphazardly. Today they (the leaders of today) do not talk with command like “our great elder” (*mzee wetu huyo*), the former President Nyerere.”⁴⁰³ Another healer noted the restrictions imposed by the government limited their freedom to use plants that they had grown, but for which they were required to obtain permits from the government to cut. “It is not easy to cut trees until you have consulted the *bibi miti* (a female forest official) to get a permit, even if you want to cut a tree that you planted in your own area.”⁴⁰⁴

Others acknowledge the involvement of the government in supporting conservation measures, even though not satisfactorily. “The government is not involved to the level that we want. I recall, however, that *bwana miti* (a male forest official) taught me how to create tree seedlings, and he taught me how to grow plants such as *mwarobaini* (neem - *Azadirachta indica*), but they did not survive. But I wanted to have a *neem* tree because it helps treat conditions such as urinating blood. Likewise, *mlonge* (*Moringa oleivera*), if prepared and dried inside and then ground and when a person drinks it, will stop bloody urination.”⁴⁰⁵ In some situations, healers have devised an adaptive strategy to obtain medicinal plants that entails responding to government recommendations to plant their own stocks for medicine. An interviewed healer while showing his premises where medicinal plants are grown (Figure 43), he noted that he inherited medicines that were grown by his father, who was also a healer. “My father

⁴⁰³ Interview Gamala Lunga, Ngamigamba Busumabu, May 25, 2010.

⁴⁰⁴ Kabu Seno, Sanungu -Lugeye, Magu; August 7, 2010.

⁴⁰⁵ Interview, Simo Rashi, Sanungu-Lugeye, Magu, August 7, 2010.

moved in here in 1984; he planted a lot of medicinal plants and I strongly support that idea.⁴⁰⁶

Healers are aware of the conditions that are beyond their control, particularly in their efforts to grow medicinal plants. One of them talked about poor soil. “I have planted trees but they never survived.



Figure 43: Healers growing medicinal plants in their residential compounds

I am guessing this is because of high

salinity (*maji ni ya chumvi*). But I have not given up. I am still having that plan of planting medicinal plants, because you can see trees are disappearing, and you have to travel far away to get medicine”⁴⁰⁷ Healers also see the damage occurring in the environment, and think collaboration with government agencies will help ensure availability and access to medicinal plants. One of the healers said, “The environment is destroyed. People are destroying it. I, as a chairman (in Sanungu Village in Magu District) of this *kitongoji* (sub-village), I invited *bibi miti* (a female forest official) and we collaborated with her to prevent the cutting of trees. But we have also received education from different agencies. For instance, we had the Viagro Forest agency, they were educating us about planting trees, and they encouraged us, and they brought experts to help us.”⁴⁰⁸

⁴⁰⁶ Interview, Sangela Ng’wela, Sali-Lugeye, Magu February 4, 2010.

⁴⁰⁷ Interview, Sangela Ng’wela, Sali-Lugeye, Magu February 4, 2010.

⁴⁰⁸ Interview, Makole Buli Mlyanongu, Sanungu Village-Lugeye, August 6, 2010.

In some villages, healers have collaborated with government officials to conserve forests with medicinal flora, as one of the interviewed healers noted:

We made *ngitili /hifadhi ya misitu* (dry-season traditional fodder reserves among Wasukuma enclosures owned by individuals families or communities aimed for natural resource management in a forest reserve) to protect areas that have plants with medicinal values. Now you have to find a village chairman to get permission in order to harvest. Harvesting is done by a healer himself.⁴⁰⁹

All of these issues surrounding the difficulties obtaining medicinal resources and the challenges of growing medicinal plants are largely determined by the availability and quality of land for the herbs to survive. This land management concern emerged as one of the salient issues during fieldwork. As one respondent said:

We request the government to help us by giving us land that we can plant our own plants. The government should direct us and should be close to us and should identify areas we can use; in future our children will suffer, because they won't have any medicinal plants remaining if we don't take care of it now. We have tried on our own; but not all trees survive at all places and every piece of land is now owned by people. That is why we request that the government help us.⁴¹⁰

Another healer shared a similar point of view:

You can now see some trees; it is true the government is now helping, because if our country becomes a desert it will be a big problem. However, in our area there is an individual called Ng'waching'wa in Kigagana village who has been authorized by the government to plant trees, and that is the area we visit to collect medicinal plants, I am not sure if he buys seeds; we thank the government by helping us with that (having individuals supported to grow plants and sell to the users)⁴¹¹

⁴⁰⁹ Interview, Mubi Makemo, Bujora Sukumal Cultural Center –Kisesa, June 23, 2006.

⁴¹⁰ Interview, Mubi Makemo, Kanyerere-Misungiw; September 3, 2009

⁴¹¹ Interview, Kabu Seno, Sanungu -Lugeye, Magu; August 7, 2010.

MEDICINAL FAUNA: AVAILABILITY AND ACCESSIBILITY

The use of animal parts in medicine (biomedicine and traditional medicine) in zotherapy are said to constitute about 15–20% of traditional medicine (Alves and Rosa, 2005). In Mwanza, the quantity of animals and their used in therapeutic activities can hardly be quantified for a number of reasons. First, the exact number of traditional healers and their practices are not known. Second, there is no centralized system where animals and animal parts are obtained. Third, enforcement of legislation can hardly be achieved, particularly regarding access to animals that are outside reserves and protected areas. Healers in both urban and rural areas possess animal parts and products that include skins from lions and leopards, lion fat, horns and tails from wild beasts, and pangolin shells, to a mention a few. The lesson from fieldwork indicates that there are both rare and endangered species in need of protection due to their demand in therapeutic activities. More often, rare species are the ones that are in high demand in the field of traditional medicine. Pangolins, otters, and rhinoceros are examples of such species that are on the verge of extinction. The Mwanza region is experiencing dramatic ecological changes in both terrestrial and aquatic environments due to multiple stressors: increased population, massive investment in fisheries and mining, intensified agriculture activities, climate change, and livestock management (Taylor et al. 2005; Canter and Ndegwa, 2002; Witte et al 1992). Interviewed healers noted that the rich ecological niche of Lake Victoria is important for the quality and sustainability of traditional medicine. The lake hosts different species that have different nutritional, medicinal, economic, cultural, and spiritual values. As one of the ecological and economical hot spots in the region, the Lake

Victoria basin has attracted many different actors, making it one of the most densely populated areas in Africa (Ntiba, 2001). Different activities in the basin threaten ecological and social systems.

Products from both wild and domesticated animals are used in different therapeutic and ritual activities. Some animals are used both alive and dead for divinations; some animal parts are processed in the preparation of medicines. Lion fat, dead snakes or parts of them, pangolin shells as well as the fur, tails, shells, and fat from wild



Figure 44: A snail for traditional medicine

animals are commonly sold in the markets. The data from archives at Bujora Sukuma Museum indicates that mammals, reptiles, birds, fish, and amphibians have been used in the field of traditional medicine for different purposes. The use of creatures in traditional medicine is determined by their physical behaviors, which helps determine if the medicine is made for good or bad intentions. Different creatures are captured dead or alive before use.⁴¹² Obtaining some animal parts, therefore, does not necessarily require killing, as dead animals from diseases or accidents can be used. Thus, whenever there is an incident in which an animal is killed, people with different motives intervene and express interest in specific body parts, according to the knowledge of their uses.

Use of wild animals

Animals such as hyenas are modes of transportation for witches and agents to inflict harm through sorcery and witchcraft practices (Hopkins, 1980), according to

⁴¹² Interview, Anthony, Kisesa-Mwanza; October 3, 2009.

respondents. One of the interviewed healers in Mwanza commented on a hyena that was hit by a vehicle. Various people competed for its body parts. The healer explained that the hyena was skinned and different individuals, each desperate for specific parts, such as the skin, liver, and heart, extracted its body parts.⁴¹³ Body parts from hyenas have been used as ingredients for different kinds of medicine such as for protection, strengthening and for witchcraft purposes (Morris, 1998).

The use of an animal is determined by its composition as well as the animal's physical behavior and symbolic traits, such as movement (linked to the health condition to be treated or problem to be attended). For instance, the flesh from snails is processed for medicine to treat *kutoka mgongo* (rectal prolapse). For this reason, in order to have effective medicine, a snail (due to its physical nature of having its flesh in the shell) is tracked when his body is out of the shell (*anatakiwe aviziwe kabla ya mwili kuwa kwenye gamba*), and cut with a sharp knife. The body part taken is dried, burned in an empty pot, ground, and mixed with other medicine before being applied. Likewise, healers treat similar conditions with millipedes, due to their physical processes of coiling around themselves. The physical processes of organisms have not been studied extensively in the field of traditional medicine and are an area for further inquiry. For instance, the rhino horn is used to treat erectile dysfunction, despite the lack of a chemical composition considered potent to treat the condition. However, the horn has a physiological erectile characteristic, a trait needed to treat erectile dysfunction in humans when "form follows function," as it has been widely used in medicine in different countries in the world (von Hippel, F. & von Hippel, W, 2002). Rhino horn use is based upon its symbolic

⁴¹³ Interview, Neche Hango, Kanyama- Kisesa, Magu; August 1, 2006.

significance. Consuming remedies made of horn, practitioners believe, enables male sexual organs to attain appearances like that of the rhino horn (Guirguis, 1998).

A healer noted that treating snakebites involves the use of *mishishigulu* (*Albizia brachycolyx*) roots that are supposed to be mixed and ground together with another snake known as *pambe*.⁴¹⁴ The use of animal and animal parts for therapies is common in Sukumaland. However, obtaining animal parts is a challenge due to the decline of animals and the national and international regulations and legislation enacted to protect biodiversity.

Divination with domesticated animals

Healers who are also diviners are more likely to use domesticated animals in their diagnoses. These animals include goats and chickens. For instance, an interviewed healer noted that if a patient complains about chest-pain, a problem associated with the heart or lungs, a healer will divine using a chicken (*kuchemba ngoko*). This process involves removing the feathers from a live chicken. The chicken is then killed and the blood vessels and other organs are examined in order to detect faults or imperfection in human organs. The dysfunction of the human system is transmitted to the movement of the blood in the chicken. The chicken's organs respond under divination to problems in the human. One healer respondent compared the use of chickens for divination to a biomedical diagnosis using X-rays:

⁴¹⁴ Interview, Mubi Makemo, Kanyerere-Misungwi, September 3, 2009.

If a chicken is given to you (members of the research team) you will just see it as meat and organs. For us this is a unique book, like the way scientists call their equipment X-ray. A chicken is capable of telling us every problem that a patient will have; we use a chicken to identify problems that people have. In a chicken, we see everything comprehensively and tell people their problems and what needs to be done to rectify the problem.⁴¹⁵

Rendering divination impossible by interfering with divination objects (e.g. chicken)

Mubi Makemo noted, however, that not all chickens are able to read all problems. “There are chickens that are not good, that cannot read people’s problems. They hide everything that a healer is trying to read and the diviner fails to register anything related to the clients’ problems.” The healer emphasized that such kinds of problems are not common, but there is a possibility for the chicken to rot just immediately after *kupasuliwa* (being dissected), making it difficult for the divination process: “Rotting of the chicken right after being dissected during divination is said be a bad sign and it implies a failure to diagnose by a healer or a calamity to the client.” Precautions are taken immediately in such a situation to forestall further problems. According to the healer, such a problem (the rotting of a chicken or the failure to read a chicken by the diviner) is attributed to sorcery and witchcraft and clients have to undergo side procedures, such as a cleansing process (*kusafisha nyota*), or using medicine *za kuzindua* (to quash the effect of sorcery and witchcraft.) Sorcerers and witches are said to be aware that the afflicted persons are more likely to visit diviners/healers and, because

⁴¹⁵ Interview, Mubi Makemo; Kanyerere – Misungwi, September 3, 2009.

of this, witches use medicine that will render diagnostic tests by healers ineffective. On the other hand, healers are aware of the possibility that their clients may have been bewitched by medicine that will have a direct or indirect effect on the medicine offered by healers”⁴¹⁶

The availability of animals for their parts in medicine and *shingila* is one of the challenges facing healers in Mwanza. For instance, Hellman Ng’wana Shoki (a healer and night guard) related that he treats cancerous wounds (*kansa ya nje*). However, the *shingila* for the medicine, made from crocodiles’ bones, is hard to find.⁴¹⁷ “The bone is dried and ground before it is mixed with other medicine and applied to the wound. Another animal product in the markets includes *mafuta ya simba* (fat from lions), used to treat some forms of cancer.”⁴¹⁸ In one of my field observations at a Maasai healer’s work station in

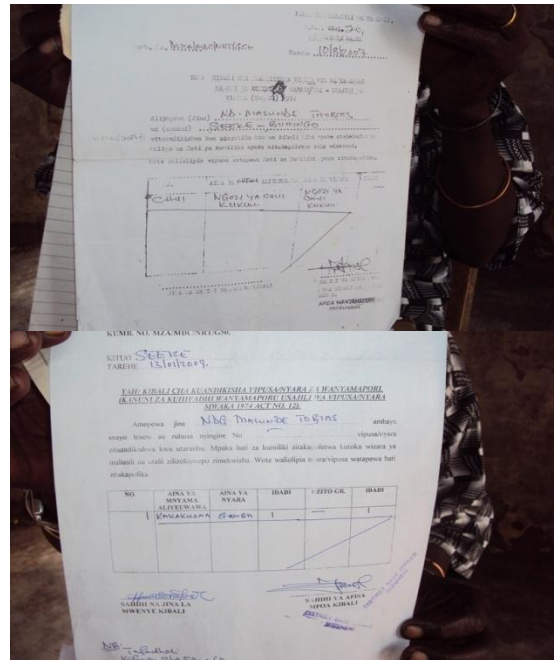


Figure 45: Certificate of ownership for leopard skin (top) and pangolin scales (bottom).

Mwanza town, two women came looking for what they called *roho ya simba* (lion heart). Having lived in the region, I was able to recognize from their accent and ethnic background that they were Kulya (an ethnic group in Mara, one of the regions in the Lake

⁴¹⁶ Interview, Mubi Makelelemo, Kanyerere, September 3, 2009.
⁴¹⁷ Interview, Hellman Ng’wana Shoki, Bujora Kisesa: June 30, 2006.
⁴¹⁸ Interview, Juma Ibassa, Bujora Kisesa: June 30, 2006.

Victoria basin about 230 km from Mwanza). I was curious to know about the uses of *roho ya simba* and how it was obtained. The Maasai healer who owned the store, named Oleluca Laze, said he sells *roho ya simba* from both male and female lions. I had an opportunity to examine what was called *roho ya simba*. It looked like a hairy ball that was the size of a chicken egg. Oleluca told me that a lion throws this from his or her mouth when it is dying. *Roho ya simba* is in high demand in the field of traditional medicine; one sells for TSH 12,000 (equivalent to US \$8) in Mwanza. However, small pieces also can be cut off and sold. One of the women suggested she preferred a heart from a female, based on the aggressiveness of female lions when hunting. Medicines made with *roho ya simba* tend to enhance human aggressiveness. Despite the inquiry about the availability and price of *roho ya simba*, both women left without purchasing.

The healer also revealed that he sold tails from *nyumbu* (wildebeest) that he obtained from from the Rukwa region. These and other animal parts are accessed and possessed by obtaining permission from the Ministry of Natural Resources. Then Oleluca explained that these *roho ya simba* were used to make *hirizi* (amulets). A person wearing a *roho ya simba* amulet is more likely to live longer; indeed, the person will never die, even if his or her body has deteriorated, unless and until the *hirizi* is removed from the body. If it is not removed, the person will be alive despite the lack of function in his or her body organs. The healer noted that the worst-case scenario is if a person swallows the *hirizi* made from *roho ya simba*. That person would live forever, despite the malfunction of body organs. Just as traditional medicines may associate the form of a medicine to its function, the use of wild animals in the field of medicine and witchcraft practices is associated with these animals' behaviors, such as destructiveness, aggressiveness,

friendliness, endurance, and speed, to mention a few. To attain these characteristics, medicines are made that can be incised on a human body, made through amulets, or smoked.

Because animal acquisition is governing by existing legislation, healers require authorization from the Ministry of Natural Resources to obtain animals or animal parts. There is a procedure, according to Lucas, for people to own *nyara za serikali* (Government trophy). The law requires a permit to hunt and restricts the use of traditional weapons such as spears, arrows and bows, the tools used by locals (Masilingi, 1996).⁴¹⁹ These stipulations are based upon the Wildlife Conservation Act of 1974, which repealed and replaced the Fauna Conservation Ordinance Cap.302. This ordinance was colonial legislation aimed at protecting, conserving, developing regulation and controlling the utilization of Fauna and Fauna products.

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Figure 46: List of prices for animals

The ownership of trophies, such as those used by healers, is stipulated in the Wildlife Conservation Act, Section 68 (i), which states that “any person who by any means obtains possession of Government trophy or who sees any Government trophy in the possession of any other person shall forthwith report such possession to the nearest Game Officer and shall, if required, deliver the trophy to the Game Officer of give particulars of the person in the possession thereof”

⁴¹⁹ Source: Masilingi (1996) Social-Economic Problems Experienced in Compliance and Enforcement in Tanzania Paper presented at the Fourth International Conference on Environmental Enforcement accessed on April 12, 2011 from <http://www.inece.org/3rdvol2/masilingi.pdf>

(Masilingi, 1996). Legal ownership of government trophies involves receipt of a certificate to register the animal part in one's possession (a trophy certificate of registration). Oleluca Laze, the Maasai healer operating in Mwanza showed his permit (No. 02254) for *mkia wa nyumbu* (a tail from wildebeest). The fee paid to own a tail appearing on the form was TSH. 3,000 (equivalent to US \$2).

Figure 45 shows certificates of ownership for leopard skin and pangolin scales. The leopard skin is useful during the initiation ceremonies of leaders (such as chiefs) in Sukuma. Skins from both lions and leopards were commonly found among the chiefs. Along with the leopard skin, this healer also owned a pangolin scale (one of the rare species that, when seen, would mean an extraordinary event is going to happen). This symbolic medical significance of the pangolin is widely known in different locales, such as in Southern Africa and Asia (Morris, 1986). The healers who owned animal parts in Mwanza noted that they have to pay fees to the government through the Ministry of Natural Resources. It is easy to protect large wild animals in protected areas and national parks, because of the restrictions on entering them. However, small animals and those that have habitats outside protected areas are at risk. In addition, not all animals or parts of them can be obtained due to the decline of species used in the field. For example, there are species that have been threatened by anthropogenic activities happening in the Lake Victoria basin. One question regarding the implementation of laws in relation to animals and animal parts concerns the way in which laws are enforced for organisms outside of national park and forest reserves.

CONSERVATION IMPERATIVES AND TRADITIONAL MEDICINE

Traditional healers process and administer therapies in many different forms. They boil roots, bark, leaves, and flowers. They process other medicine by grinding leaves, roots, and bark to add to tea, porridge, milk, soup, water, or juice. Some medicines are first burned in a pot before they are ground and stored in gourds, plastic bottles, horns, paper, or plastic bags. Other medicines are soaked in water for a defined amount of time prior to use. These various processes determine the shelf life of the medicinal products.

The short shelf life of medicine prepared by healers has implications for people's health and for nature conservation programs instituted by the government. The preservation and storage of medicine remains a major challenge for healers. This problem extends to consumers as well as the programs aimed at optimizing the use of biological resources. Each plant has its own shelf life. Some plants can naturally last longer due to their chemical composition. Healers noted that plants like *Ng'wicha (Kigelia africana)*, used to treat anemic people and increase mothers' breastfeeding ability, could last for more than three years after harvest. However, concoctions made from other plants are likely to last for only two or three days, according to healers.

The medicines offered by healers often do not have proper labeling to indicate shelf life and expiration date. This situation puts consumers at risk. In addition, healers lack a strategy to improve shelf life. This lack maintains high demand for fresh trees, which adds more stress to forest resources. One healer noted that a concoction can hardly be kept for more than two or three days before the medicine is thrown away and fresh plants are needed. The increased epidemiological crises and the lack of measures to store

prepared medicine over extended periods of time lead to an increased consumption rate for relevant plant and animal materials, particularly without sustainable harvesting strategies.⁴²⁰

The need for new technology to process medicine

Healers continue to use the same techniques to process medicine, but even they see that their systems need to be modernized. For instance, the drying and grinding of medicine remains a tedious exercise. As one healer noted, “Preparing medicine is one of the major challenges and it would be good if we could obtain machines to dry and grind these medicines.” Another interviewed healer noted that they spend a lot of time processing medicine. A healer who was in charge of initiating activity with other healers echoed the need for machines to facilitate easy processing of medicine; it is a cumbersome task. One aspect healers would like to see in their activities includes machines that could simplify work. But such changes present the dilemma of tradition versus modernity among healers. Seeking new technologies entails deviation from their widely recognized form of knowledge that is traditionally embedded in locally adapted culture.

High temperatures, varied storage facilities, and lack of refrigeration systems for both healers and their clients render existing processes of medicine storage ineffective over the long term. Likewise, the technology of additives that would improve the shelf life of the medicine is still unknown, insufficient and unaffordable for the majority of the

⁴²⁰ Jolema Delusi, Bujora Kisesa-Magu; June 30, 2006.

healers. Healers noted that they have to emphasize to their patients the need to consume medicine within a certain amount of time in order to avoid health risks caused by expired or spoiled medicine. They also noted that giving expired medicine to patients is a problem to be avoided. Healers emphasize that people consult them for treatment, not to become sick for consuming medicines that have expired. Healers depend upon their reputations in their communities. Just as it is with biomedical field collection, processing, storing, advertising, and administering all impact the important intangibles: credibility, fame, reputation, and legality.

Interviewed healers noted the importance of maintaining credibility; this determines their legitimacy. One of the strategies to gain credibility is to offer a quality service that entails administering medicine that is properly preserved and stored. When asked how they ensure that their medicine is properly preserved, one healer noted, “This is a problem. There are ingredients to be added to improve the shelf life of our medicine, but they are expensive and the instructions given are not understood, and we fear adding it will ruin our medicine.”⁴²¹ Despite some healers’ interests in modern technology, such as the use of additives to increase shelf life, other healers strive to maintain traditions when processing traditional medicines. Therefore, this group of healers opts for active choices not to standardize, mechanize, and regularize their industry. Healers are aware that profits can be made in the absence of controls, also. In addition, the quality of traditional medicine responds to ritual practices that are subtle and complex and believe formulas for quality that are advocated with Western ideals. Jolema Delusi, a healer,

⁴²¹ Interview, Jolema Delusi, Bujora Kisesa-Mwanza, June 30, 2006.

noted that chronic diseases take a long time to be treated, and occasionally involve altering the medicine. This circumstance, while adding costs, also increases the amount of medicinal resources healers can obtain from the natural environment. Healers also respond to variation in climatic conditions by harvesting and storing sufficient medicine during dry seasons to treat long-term illnesses.



Figure 47: Storing tree backs used to prepare medicines

Preparing medicine, a seasonal task

In August 2009, in Kanyerere-Misungwi, I observed a healer, Mubi Makemo, gathering herbs for his therapies and followed different procedures he invoked in collecting medicine. He explained that summer is the best season to harvest medicine, as it allows time for the plants to dry. During summer, healers collect enough medicine to use during the rainy season. The healer explained, “For a task like this (harvesting and processing medicinal resources) you can harvest more than thirty species in a week if you are not tired, because we do it once a year. We accumulate a lot of medicine (Figure 47); *jua huwa ni kali* (‘it is hot during this time of the year’), and medicine will dry properly, but it is not like that during the rainy season.”⁴²²

⁴²² Interview, Musobi Makelelemo, Kanyerere, September 3, 2009.

Plastic vs. Natural Storage Containers

Storing and packaging of the medicine is one of the challenges many healers face. The government has



Figure 49: Polymer materials, gourds and glass bottles used by healers to store medicine.

advised healers to have lockers and proper storage for medicine to ensure safety for the consumers. Many

healers adhere to the government order to have a shelf on which to keep their medicine, while others do not (Figures 48 and 49). Storage shelves are invariably populated by polymer bottles and lack any traditional storage containers (Figure 49).

While the government and international communities strive to reduce the use of plastic materials for environmental reasons, healers see the use of plastic bottles as important, since they ensure the

effective storage of their medicine. A huge amount of plastic waste accumulates in the



Figure 48: The storage shelf with plastic containers used to keep medicine. The two pictures below show the traditional equipment used to store medicine including hides and horns.

environment and affects both terrestrial and aquatic organisms (Derraik, 2002). Used plastic bottles and bags, however, find their way to the healers who use them as packaging and storage materials for traditional medicine. Similarly, clients bring plastic bottles to the healers for the concoctions they receive. Despite the ironic circumstances, healers play a key role in recycling and reuse to manage non-biodegradable materials that would have been released into the environment. The transition in storage and packaging materials among healers is a result of the decline in the availability of natural products, such as gourds, or hides or horns from wild and domestic animals that were used in the past. This shift from locally obtained materials to synthetic ones shows how various practices respond to global market pressure and technological innovations.

Climatic conditions, weather patterns, and healers' response to changes

This chapter, and my broader environmental history of indigenous and traditional healing in this thesis, has described numerous challenges faced by healers and the populations they serve. One of the biggest challenges they face is one of the most diffuse, and will be far more difficult for them to address than colonization, the expanding state, or debilitating diseases and rampant exploitation of their resource base: this challenge is the changing climate. A report by the Lake Victoria Basin Commission indicates that the average temperature increased by one degree centigrade between 1950 and 2005. These new climatic conditions have altered the responses and adaptations of vectors for infectious disease (Grifo and Rosenthal, 1997; Odada et al. 2004). This change is also shifting the distribution of medicinal flora and fauna, as well as the practitioners who use these medicinal resources.

Healers' Migration due to Climate Change

Tanzania is increasingly experiencing the impacts of climate change in its economy, agriculture, livestock keeping, water resources, and power supply. A study by the UK Department for International Change in Tanzania estimated the loss of over two percent of the gross domestic product (GDP) by 2030 (Watkiss, Downing et al. 2011).⁴²³ General Climate Models for future scenarios show increases in country-averaged mean temperatures of 1.3°C and 2.2°C, projected by 2050 and 2100 respectively (Agrawala S, Moehner A et al. 2003). It is difficult to assign specific changes in specific regions to climatic changes. However, the Lake Victoria Basin Commission indicates that water levels in Lake Victoria decreased dramatically between 2002 and 2005, largely due to changing rainfall patterns and increased evaporation.

Studies show some links between climate and environmental change and people's mobility (Black, Adger et al. 2011; Tacoli 2011). Traditional healers, like other social groups, have to confront and adapt to the impacts of environmental and climatic changes. Healers are affected by climate change on multiple fronts due to their roles as healers, livestock keepers, and farmers. Climate change is altering agricultural and livestock management practices, the spatial arrangement of people, ritual spaces, disease vector-human relationships, and the variability and access to medicinal resources. Changes in

⁴²³ Source: Planning Ahead: International Workshop Supports Tanzania Climate change Strategy accessed on March 3, 2012 from <<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/ENVIRONMENT/0,,contentMDK:23087692~menuPK:176751~pagePK:64020865~piPK:149114~theSitePK:244381,00.html>>

climatic conditions influence changes in social structures; the reconfiguration of different actors in different environmental landscapes is based on their activities.

Healers are among the groups who have responded to climate change by migrating to new areas. The Mwanza region, for instance, hosts different groups of healers from different regions who claim that they have come to Mwanza for *kubadilisha mazingira* (changing working environment) or *kutafuta maisha* (to explore opportunities for surviving). A word of caution is important here. The selection of a work environment may not necessarily be related to climate change; advancements in medical practices may cause fewer people to patronize healers. In other words, migration to new places is ascribed more often to the search for economic opportunities. Studies in Maasailand indicate altered conditions related to climate change, including timing of the rain. Observers noted that rain comes later now than it did in the past. This condition affects farming and livestock keeping. Severe droughts in the 1997, followed by El Nino-related floods in 1998, affected crops, worsened soil erosion, and increased outbreaks of Rift Valley Fever that decimated cattle (Tacoli 2011). The region also experienced scarce rainfall between 2000 and 2002, and again in 2009-10. These varied climatic conditions have caused large numbers of livestock deaths. The 2009 drought is considered the worst in the past 40 years, and pastoralists lost up their livestock in large numbers due to this drought. As a result of climate change and other social changes, such as increased land value and conflicts, Maasai healers from the Arusha region have increasingly moved their operations into different areas, including Mwanza town (Tacoli 2011). The Maasai have changed their forms of livelihood, moving from livestock keeping to selling products in urban areas. Their movement to Mwanza has resulted in increased competition with the

native Sukuma healers in Mwanza town. A wide body of literature discusses the socio-economic conditions that have assisted in pushing Maasai healers into other territories (Ibrahim and Ibrahim, 1998; May 2003). Thus, changes in the climatic conditions have impacted healers' migration patterns, as well as access to medically important flora and fauna.

Climatic fluctuations, observed over the years and through the narratives of healers, indicate that there are new configurations of healers and new meanings of health and medical practices. A Maasai healer from Arusha, operating in Mwanza, recalled the weather change, and its impact upon livestock, the most dependable economic resource for Maasai people:

Drought persisted for a certain period and it was somehow better in March, April, May, June and July; the drought was serious in August, September and October of 2009. Imagine last year a person owned one thousand cows but in a four-month time he is left with only one hundred cows with the others having died of hunger. Livestock keepers had to buy residues from rice paddies in order to feed their livestock.⁴²⁴

Maasai mobility and occupation is linked to varied rainfall patterns that are not well suited to livestock and agricultural activities in their home region. Often when people move to new areas, they must be inventive in establishing livelihoods. Among the Maasai people, both men and women have migrated from their native lands and are now encountered in large numbers in various urban areas in Tanzania performing duties such as night guards, sellers of traditional medicine, and hairdressers. Maasai healers operating in Mwanza are practicing medicine in Mwanza because of economic hardship and the unreliable rainfall that brought drought to their homeland. Climate change alters healers'

⁴²⁴ Interview, Oleluca Laze, Mwanza City, February 2, 2010.

access to medically important flora and fauna. Changing environmental conditions also shift bases of knowledge and power among healers.

CONCLUSION

Human health depends on biodiversity and on the natural functioning of a healthy ecosystem (Alves and Rosa, 2005). Despite increased interests in and importance of traditional knowledge and medicine in recent years, the threats to traditional medicine are now greater than ever. Disappearance of traditional knowledge in the form of cultural heritage (Naur, 2004) occurs in three forms. First, there are diminished numbers of people who have the knowledge as generations pass. Second, the existing structure for environmental governance does not adequately engage aspects that are essential to sustain traditional medicine. Third, the resource, in terms of biodiversity and language base where traditional medicinal knowledge exists, is threatened. The loss of biodiversity with medicinal values raises concerns, not only conservation concerns, but also economic concerns for populations that depend on herbal medicine as their source of income.

Alternative and complimentary therapies are now accepted and increasingly consumed in the West (Erickson 2008). This consumption will continue to increase resource exploitation in the search for medicinal resources to feed both local and the international markets. Studies in Asia and Africa have covered the threat of the international trade of endangered and rare species used in the field of traditional medicine. It is imperative for its survival for traditional medicine to become a variable in conservation programs, the protection of endangered species, and the improvement of livelihoods. Development processes and economic advancement depend on a society's

capability to produce, acquire, deploy and control valuable scientific knowledge
(Dutfield, 2006).

**CONCLUSION AND RECOMMENDATIONS:
CHAPTER 9
CONSERVATION IMPERATIVES AND TRADITIONAL
MEDICINE**

Globalization according to McMichael et al. (1999) and Schrecker et al. (2008) influences both environmental and social change, and the most affected groups are vulnerable ones in the developing countries. In addition, global market forces affect biophysical systems while simultaneously contributing to the shrinkage of the health and education budgets at social level. In Mwanza, commercial production of Nile Perch in Lake Victoria and regional mining activities have lured labor from surrounding regions. The Mwanza region thus experiences a collision of forces including migration, poverty, competition over resources, foreign resource exploitation, environmental and demographic change, and epidemiological crises that challenge people in the region, often making it a struggle for them to meet their daily needs. The changes that these extractive industries are causing politically, economically, socially, and environmentally have become critical in the discourse of the region and have emerged in the international discourse through film and documentaries that feature Mwanza residents as victims of globalization. This project, however, has honed in on a category of actors, healers, who are a resource or solution to such stressors while also themselves being subject to changes in their practices, materials, reputations, and thus increasingly vulnerable to competition,

criminalization, and conservation measures that further exclude them from their traditional resource base of animals, plants, and land. Some studies have hypothetically examined the links that exist between ethnomedical practices and environmental degradation as well as the conservation of biotic communities in this current era of globalization (Anyinam, 1995; Alves and Rosa, 2007). However, changes in the environment that are happening in the Mwanza region are also transforming social structures and cultural conditions.

I have used the situation in Mwanza to illustrate the concept of nested and interactive vulnerabilities that result from such social changes, as they are experienced differently within and between various marginalized groups. Some, in this case healers' clients, risk being ever more marginalized. Others, such as healers, mediate or modify those threats, but are themselves experiencing rapidly changing purviews and political economies of healing. This nested and interactive vulnerability reveals Sukuma social fabric, identity, and adaptive capacity. Likewise, the reaction of traditional healers in different stages of social and environmental periods/changes/episodes demonstrates how they adapt to society through their knowledge of the environment and health, their leadership role, and their inclusion in society.

Beyond the conceptual level, with respect to wider theoretical literatures and fields of inquiry, in Mwanza we are seeing the intersections of both structural violence and environmental justice issues,⁴²⁵ where extractive industries such as mining and

⁴²⁵ Structural violence: institutionalized practices that have negative effects and limit people achieving their full potential. Environmental justice: cultural norms and values, rules, regulations, behaviors polices and decisions that support sustainable communities where people can interact with confidence that their environment is safe, nurturing, and productive.

fishing magnify a “risk society” by exacerbating poverty, HIV/AIDS, inequality, and crime. Other effects of this intersection include unfair distribution of environmental benefits and costs, exclusion (land dispossession to allow investors to operate), externalities, inequality, diseases, infections, and limited access to health care services. I present healers as mediators who bridge medical and environmental arenas historically and actually, thereby offering a novel combination of literature on structural violence with respect to basic health care access with Environmental Justice literature which focuses on exposure to toxins, nutritional risk, economic insecurity, exclusion, and externalities.

While the first part of this thesis reviewed historical transformations in healers’ work and social roles vis a vis communities and the Tanzanian state, the second part traces the interaction between structural violence and environmental injustices as they link causally and broadly, culturally, to experiences of HIV-AIDS, victimization of visible minorities (albinos), and new environmental politics that displace healers as protectors of resources and providers of plenty. These latter chapters emphasize the severity of these challenges to healing traditions. For instance, the killing of albinos provides a complicated glimpse of the links between processes of racial identity, competition of declining resources, the changing role of traditional medicine and witchcraft and valuation of body parts in resource access and accumulation. Likewise, the influx to Mwanza of migrant labor links to epidemiological crises such as HIV/AIDS that have created new markets for immune boosting remedies and fertility potions that are sold in store fronts as commodities rather than being administered in the intimacy of a socially embedded, long term healing relationship.

Yet I argue that these conditions are not only obstacles for healers; they are also opportunities. The circumstances described above have increased the demand for traditional healing practices to provide contemporary therapeutic approaches for health and security affairs. This in turn means more confusions and conflicts between healing practices and witchcraft practices in contemporary Mwanza society. Healers are seen as saviors responding to people's security, economic, and health concerns. However, healers themselves are vulnerable due to structural violence, economic asymmetry, and the restricted access to medicinal resources resulting as an outcome of environmental degradation and national and international environmental conservations programs.

Political Trajectories of Traditional Healing in Tanzania

The institution of traditional medicine is politically contested and governmental policies and interventions intentionally or unintentionally contribute to the trajectory of healing practices. Contemporary healing practices in Tanzania are a result of political transition from the colonial period to an independent government setting its own policies. There are varied opinions about the government role in supporting activities by healers. The majority feel that the government has not been effective in accepting the field of traditional medicine, nor given healers the any support to sustain their activities. More often, healers have been challenged by the government who claim that traditional healing practices such as divination instigate violence and are therefore a threat to society. For their part, healers recognize that there is little support from the government for protecting the forest resources that they use as medicinal bases. Yet national policy could be crucial to create a more supportive context given the daily struggles in the region that pit healers

against other healers and different forms of healing knowledge in the governance of community life through articulations of new afflictions and the emergence of new medicines.

Forces of transformation that have affected the field and position of traditional healing practices include Ujamaa villagization that to a large extent has restricted, controlled and disparaged the field of traditional medicine. The Ujamaa villagization exercise in the early 1970s embraced the idea of togetherness and familyhood and people in scattered areas were resettled in designated places. However, the purpose of Ujamaa villagization was to maximize state control and the provision of social services, free up agricultural land, control labor, resources, and the market. Both peaceful and coercive approaches led to numerous losses and changes in the field of traditional medicine. Healers lost medical paraphernalia, medical landscape and built environment. In addition, healers' legitimacy, power, and fame were compromised. Likewise, healers' activities were restricted because of the government control of space and ideas as modern ideas and biomedicine were highly promoted. Despite pressure from the government controlling and inhibiting the application of traditional medicine, healers have strived to reclaim their identity, autonomy, legitimacy and power in many different ways.

Due to political vulnerabilities that healers have experienced over time, they have responded in varying ways in different eras. Patriarchal power based on prowess as pastoralists was a dominant strategy precolonially. Colonial interest in collective rituals and performance made for an oratorical and performative repertoire that has been passed down across generations of healers. Political identities as better security agents than the state prevailed among healers during the postcolonial war with Uganda in the 1980s that

saw the Sungusungu militia emerge, and becoming entrepreneurs in the current moment. Sungusungu vigilantism became a social movement that addressed the lack of government enforcement of social security by providing community health and security. The movement to a great extent embraced traditional medicine as a mobilizing tool for protection, security and social cohesion in communities. The paradigm and discourse of traditional medicine brought confidence and fear in society which became a social control mechanism.

My analysis of the Sungusungu movement and its central component of traditional medicine are useful in contextualizing a collective identity and the maintenance and formation in times of crises and change. The presence of the Sungusungu was vital to the reduction of crimes in the 1980s and 1990s. Therefore, the movement was beneficial to the government. Yet, despite success in taming crimes, the movement was seen to be interfering with enforcement agencies. The Sungusungu army was seen as violating the Tanzanian constitution by punishing people without taking them to court. In addition, some punishments were considered to be violations of human rights. In such situations, leaders and members of Sungusungu were arrested and jailed. Likewise, the army lost the needed political support from the government. Consequently, people were no longer motivated to work with Sungusungu. Furthermore, people were less confident with the security of the movement due to the decline of the use of rituals and protective medicine for the members and the army.

Throughout these changes healing has remained a male dominated sector, at times even violently so. Internally, the Sungusungu army kept a patriarchal structure even while retaining and redefining collective rituals while adapting to social change. The

Sungusungu movement embraced the idea that males with knowledge in medicine could become political leaders, while medicinal women had only a limited administrative role and were more often accused of witchcraft than their male counterparts. Further work, perhaps by female scholars, could uncover parallel or intersecting traditions of healing that have coevolved with the more dominant traditions chronicled here, and at times have conflicted with them.

More generally healers, their practices, perceptions, and changing clients are a good indicator or litmus to contextualize transformations in Mwanza in light of the area's changing economy and ecology. Healers interact with more than eighty percent of the population on a daily basis, and thus encounter an excellent cross section of ailments and tensions being experienced within local populations. It is crucial to bear in mind that within Sukuma legacies, traditional medicine is a subset of healers' livelihood activities. Its existence is embodied in what healers are doing on several interconnected fronts as farmers, livestock keepers, entertainers and educators, security providers, and citizens of the society. Their multiple social roles give them a unique position for understanding different process taking place in a society. In other words, healers are at the center of ecological change and globalization processes and are in a position to inform how their practices are affected by government policies, migration, and climate change.

Recognizing Integrative Healing Practice in Changing African Contexts

Despite high demand for traditional medicine, traditional healers now experience significant competition from each other as well as from drug companies. Healers' presence in large numbers in urban areas, as seen in Mwanza, suggests that healers, like

other economic actors, are equally competing in a globalized world and are rapidly adapting to the global discourses for the use of natural and herbal products. There are different groups of healers operating in Mwanza, making it a medical field where healer's fame, power, authority, and legitimacy is determined by economic capital, cultural capital, social capital, and symbolic capital (Samuelsen, 2004). Healers seek these forms of capital through continuous search of medical knowledge from others, incorporating aspects of biomedicine into their practices, advertising their therapies, migration, and creating adaptive and accommodative therapeutic built environments that can capture a wide range of customers. In addition, healers operate in multidimensional and multidisciplinary ways within their known local medical intra and inter-medical approaches while at the same time embracing the modern aspects that are compatible with their systems.

In their search for medicinal materials and in performing rituals, healers' interactions with the environment are especially intense and frequent. Part of their power depends upon the environment. Healers bring these lived experiences of the political, health, environmental and economic status and changes into the songs that they compose to entertain and influence people. Like unstable atoms that strive to gain stability by losing or sharing electrons with other atoms, healers strive to gain stability by incorporating modern ideas into their field in order to capture customers in the modern world who are more like to embrace modern values.

For instance, many healers interviewed are emphasizing the need for their clients to undergo medical tests before visiting them. This measure is in response to the decline of traditional diagnostic methods of divination, a decline of materials and scrutiny by

the government. The packaging of medicine to the large extent has moved to synthetic material such as bottles and plastic materials that deviate from traditional means of using gourds, leaves, horns and skins from animals.

Healers are also adjusting to contemporary settings by embracing modern modes of transportation. Mobility for healers and patients is now facilitated by available communication and transport services such as mobile phones and motorcycles (Figure 49). Since colonial times, the years, healers and clients had used bicycles as their mode of transportation in rural areas. Likewise, communication was made through physical contacts between healers and their clients (see also

Hunt, 2002). However, the advancement in communication and transportation through globalization has allowed for the acquisition of mobile phones and motorcycles that have been spreading fast in rural areas. People buy Chinese mobile phones because they are sold at affordable prices, and they



Figure 50: Some healers now own Chinese-made motorcycles that help their movement visiting clients and collecting medicinal resources

become popular to the extent that people refer to this possession in terms like *cha mchina* (made in China). Others opt to buy motorcycles sold at a prices ranging from TSH. 800,000 to 1,200,000 (equivalent to US\$ 530 and 800), which is an affordable price for people with moderate incomes. Motorcycles now facilitate carrying patients to healers or to biomedical units, reaching places that can hardly be reached by cars. As one of the interviewed healer noted: “I help neighbors (by using my motorcycle) when somebody

wants to go to the hospital.”⁴²⁶ Chinese technology is therefore facilitating the circulation of medical therapies and knowledge, interactions between healers and their clients, and increased human activities on the environment. A capability for both healers and clients to travel fast and far is a blessing. Mobility allows healers to expand their networks of clients and communities they serve. Healers are now capable of securing medicinal flora and fauna at places that were not accessible without having these modes of transportation. On the flip side, however, this increased area of operating threatens forest and natural habitats that were only protected because of their limited accessibility. As Asian investments, technologies, and cultural/geopolitical influence expands rapidly in Eastern Africa, such trends merit further research.

Recommendations and Final Considerations

From a combined practical and policy perspective, it is appropriate to build a knowledge base that examines the link between resource management, health conditions, and medical practices, by examining healers’ perceptions and practices. Such knowledge must start by recognizing that consumption of traditional medicine in Tanzania is mainly influenced by the need to respond to a particular disease. More often, traditional medicine exists in multiple ways with biomedicine, resulting in various forms of intersection such as conflict, complimentary, parallel, or sequential.

⁴²⁶ Interview, Robesi Chereni, Matala, Busunguku-Mbarika Misungwi; March 16, 2010.

Healers as Bridges to Biomedicine

This thesis describes a range of healers' relationships to and with biomedical practitioners in this African theater for the interlinked struggles against HIV/AIDS and poverty. The HIV/AIDS epidemic has influenced inclusion of healers' practices in national and international health discourses and programs. Still, healers, like their biomedical practitioner counterparts, are confused by the disease and have created different social constructs about it ranging from infections, symptoms, effects to the individuals and community, and on preventive and curative measures. Similarly, HIV/AIDS is creating new forms in the medical field where healers are now residing in areas where there are more customers of HIV/AIDS. In addition, the persistence of HIV/AIDS in society has enabled healers to classify symptoms of people suffering from HIV/AIDS. However, healers' characterization of the symptoms fall under stage three and four of the WHO staging systems of HIV/AIDS, demonstrating a lag in their patients' response to seek medical help when compared to patients observed in Western biomedical programs.

The HIV/AIDS epidemic has increased demand of traditional healing therapies, raising healers' profile, creating new forms of geospatial arrangement of healers, and enhancing collaboration between healers and biomedical practitioners. Healers interviewed noted that they are more likely to encourage their clients to undergo testing particularly when they see that they have symptoms for HIV/AIDS. Likewise, healers have another unique role, particularly in awareness campaigns about HIV/AIDS. My field work indicates that healers are informally participating in awareness campaigns through songs and narratives, an aspect that has been neglected in preventive measures

for the national HIV/AIDS programs. Recorded songs from healers have messages about the magnitude, causes, effects and preventive measures for HIV/AIDS.

Healers as Social mediators or “Saviors” for Most Basic Vulnerabilities

Traditional healing is a transforming industry - and one that demonstrates new forms of medical entrepreneurship. It is also a sector where legacies of socially embedded therapeutic practice are under intense competition from market centered biomedical interventions. The latter operate increasingly in socially “thick” terms, defined by key practitioners Drs. Paul Farmer and Jim Kim as “accompaniment” of those who are suffering the structural violence of poverty and associated disease, and adhering to complex long term therapeutic regimens. At the very moment when transnational biomedical interventions such as antiretroviral drug rollout are becoming framed in terms of social interaction and “accompaniment” of those who suffer, traditional therapies are also increasingly commoditized, packaged, and marketed as “products” rather than processes. Government and policy makers can involve healers to assess and understand change in an age of proliferating “assessments” that include “Integrated Health Assessments” and “Integrated Environmental Assessments.” In other words, improving communication between healers and national and international agencies on health and environmental legislation is of great importance.

Healers as Actors in Environmental Conservation Programs

Despite national and international interest and measures to protect biodiversity, the involvement of traditional healers (who are among key consumers of biological

resources) in conservation programs remains peripheral. Ethnographic research has revealed that the position of healers are intrinsically linked by the micro-level conditions of villages in Tanzania and the macro-level conditions national and international policy institutions that govern health and environmental issues. On the other hand, conservation of biological resources depends on how local people are involved and how their knowledge is embedded in programs aimed at ensuring sustained livelihoods and improved biological resources.

Healers have knowledge of levels and geo-distribution of medicinal flora and fauna - particularly for the ones that they use. This knowledge could be vital for conservation efforts in that they can recognize threats to specific species and measures that need to be incorporated to restore flora and fauna that are threatened. The conservation efforts could be effective by tapping into the knowledge that healers have on environmental conditions and distributions of species. For instance, healers can participate in efforts to determine and identify species that are outside reserves and parks that are in high demand or threatened. The discussion of ethno-medicine has paid much attention to how resources in reserves or national parks are accessed and consumed. This consideration has neglected the wide range of species that exists outside protected zones, national parks, and forest reserves.

There are plant and animal species outside protected territories that are widely used in the various fields of traditional medicine. These organisms are threatened because there are no effective measures to protect them. On the other hand, healers noted that they are challenged by the restriction on biological resource conditions that affects the quality of traditional healing therapies as well as healers' livelihood when their income depends

on their healing practices. Healers are adapting to these challenges and they now purchase medicinal resources in markets. Others have to travel long distances to secure medicinal resources. The field work also showed that some healers are establishing gardens for medicinal plants, whereas others ask their clients to bring specific materials needed to prepare therapies.

In terms of conservation of medicinal flora and fauna, healers are challenged by techniques that would have increased the shelf life of the harvested and processed medicine to reduce the pressure to the natural base for medicinal flora and fauna. The field observation revealed that high temperatures, the use of various storage facilities and a lack of refrigeration systems for both healers and their clients render existing processes of medicine storage ineffective. Existing technologies to improve the shelf life of traditional medicine is unknown, insufficient and unaffordable for the majority of the healers. Improved harvesting and storing of medicinal product could be a way to reduce the pressure on the environment.

Influx of New Healers and Amalgamation of Medicinal Knowledge

Traditional medicine is more than physical well-being and it includes political, cultural, social and resources management. The literature in medical anthropology theories has established the way in which medical practices are a component embedded in cultural systems and differs across ethnic groups. In other words, a particular medical system is about a therapeutic landscape, influenced by historical evidence, geographical condition, political context and socioeconomic condition through which definitions of health, illnesses and corresponding therapeutic approaches are contextualized through

communities in which therapeutic approaches are defined and medicinal knowledge is made (Anyinam, 1990; Alves and Rosa, 2005; Williams, 1998).

In addition, healers interact with diverse groups of clients coming from different ethnic groups seeking therapies in health, security, and economic affairs. Different groups of healers operating in Mwanza can hardly be categorized using their knowledge as indigenous or local. These distinctions (indigenous, local, and traditional) in Mwanza are blurred by many different factors including the ways in which healers gain knowledge that involve mobility among healers in acquiring knowledge and securing medicinal resources. A majority of healers interviewed have not been sedentary. Instead, they have moved from one place to another voluntarily or by force like during the Ujamaa villagization. In addition, materials/medicine that healers use are obtained from different localities or brought by people who have travelled from different places. Likewise, healers are interacting with diverse groups of clients with different ethnic backgrounds. Therefore, medical practices in Mwanza from different groups of healers is an **amalgamation of medicinal knowledge** and skills obtained through experience and interaction of healers with varied groups of their teachers, operating in varied environments that can hardly be characterized as local, indigenous or traditional.

Changing climate remains one of the biggest challenges that healers face as it is one of the challenges that is most diffuse, and will be far more difficult for them to address even than colonization, the expanding state, debilitating diseases and rampant exploitation of their resource base. Assessment of the impacts on climate change to the field of traditional medicine and the subsequent effects to people's livelihood is very much needed. For instance, Maasai healers have left their native land in Arusha as more

arrive from over the border in Kenya, in part displaced by migrations further north due to militarized conflict and increasing climate extremes. Many Maasai healers now operate in Mwanza. Clients in Mwanza seeking therapies from the Maasai are getting therapies that are not local, and the Maasai operating in Mwanza are using medicine that are not local to the consumers. Similarly, Sukuma healers operating in Mwanza have to buy medicine in the market in order to prepare their own medicines. The medicinal resources bought are sold by individuals who are not necessarily from the localities where healers operate. Medical knowledge and practices, like other social activities, are products of specific historical and social contexts, and are determined by spatial and temporal conditions.

My work is about environmental justice, traditional healing practices, and nested vulnerabilities of different actors where both social and environmental forces interact. This work has demonstrated the way in which colonialism, the postcolonial socialist state, and now neoliberal economic policies and private sectors have shaped the ways in which healers interact with their clients over time. The project started with the historical premises of the healers as a group accounting for the contemporary activities, governmental policy and its effects, effects on the environment of global market forces influenced by foreign investment in extractive industries (e.g. Nile Perch and gold) and micro extraction activities (medicinal plants used for healing), all of which characterize the complexities of combating growing economic and medical insecurity in Mwanza region populations. In addition, my research has shown how the client base for traditional healing in Mwanza has changed over time due to economic development, environmental change, and endogenous forces.

My work has captured the terrain where global health and environmental justice concerns meet grounded Africanist historical and ethnographic work. The interdisciplinary nature of this situation is of great academic significance to my research. It touches the following disciplines: environmental change, resources management, development studies, public health and environmental justice, cultural and medical anthropology, human and disability rights, African studies, and ethnographic research. The practical application of my work is to enable policy makers' development of strategies on the ways in which health services offered by healers can be improved while sustaining availability and access to medicinal resources. Likewise, this work raises the profile of traditional medicinal knowledge, thus benefitting its custodians as mediators of ecological, social, and epidemiological needed.

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