In the spirit of Uganga - inspired healing and healership in Tanzania

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Chapter 2

The role and history of Uganga

The history of uganga in Tanzania goes back far beyond the establishment of Western contacts and was part of the political and religious belief systems of the early inhabitants of Tanzania. The authentic Bantu term uganga denotes the art and profession of medicine and healing and the term waganga (sing. mganga) signifies those who practice it (see 1.1). Uganga was an institution that combined religion, sorcery, witchcraft, health and interpersonal conflict in one single form of cultural belief and practice (Katz and Kimani 1982). Before the arrival of missionaries and the colonial conquest starting around 1880, traditional healers and the political leaders with whom they were allied, had wide control over the social conditions of health. The waganga were generally people of high integrity and status as they could alleviate social, psychological and physiological problems (Mesaki 1998). Many of these waganga owed their status to the fact that they were spirit mediums as well. If the waganga did not exert influence on local political leaders, it was because the leaders were waganga themselves. Those waganga who had connections to the spirit world, gained their prestige foremost by handling conflicts between community members. Their political involvement was thus socially accepted.

Generally, the role and status of uganga has changed a great deal in the last two centuries. To gain a proper perspective about the present role of the waganga wa pepo, it is useful to look at the changes and dynamics that have taken place in uganga in Tanzania. The insights are equally important to frame the personal histories and the role and practice of the various healers I present in this study. I realize that attempting to reconstruct the past of uganga is fraught with numerous difficulties; not only because written documentation is scarce, but also because oral evidence is hard to come by. The data for this chapter relies mainly on information from Simeon Mesaki, (1998) who wrote a SAREC report called The changing role of traditional medicine and healing in Dar es Salaam: 1920-1990; Gloria Waite (1992) who wrote: A history of traditional medicine and health care in pre-colonial East-Central Africa; and Ann Beck (1981) who wrote: Medicine, Tradition and Development in Kenya and Tanzania, 1920-1970. I obtained other historical and anthropological data from: 1) my visits and studies with the various
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healers in the country; 2) active members of the National Association of Traditional Healers and Midwives in Tanzania; and 3) personal contacts with Tanzanian and American scholars.

Before giving an outline of the historical events marked by migrations, tribal wars and colonial conquest and how these events have influenced traditional health care today, I shortly outline the geographic and demographic setting of the Southern regions of Tanzania which are the main focus of this study. These regions (mikoa in Kiswahili, sing. mkoa) are Iringa, Mbeya, Ruvuma and Morogoro (see map of Tanzania). Each region is subdivided into districts (wilaya). The estimated numbers of the population per region are based on a 2002 consensus. The entire population of Tanzania in 2002 is estimated to be 34 million, whereas during the beginning of my study (1990) this was about 23 million. In other words, there has been a high population increase in Tanzania.14

The prophet healer Nambela practices in Mbozi district, Mbeya region, an area that is predominantly inhabited by the Wanyihya and the Wanyamwanga.15 Mbeya region is estimated to have over 2 million people, dominated by the Wanyakyusa, Wanda, Wamalila, Wandali, Wafipa and Wasafwa. Besides the Wasukuma, the Wanyakyusa tribe of more than half a million is one of the largest and most influential tribes of Tanzania. They occupy the low ground in the watershed of upper Lake Nyasa, nowadays Lake Malawi. Lying immediately along the high ground are the other tribes living in the mountainous areas, including Mbozi district. The healer Jeremana Livifile practices in Njombe district, Iringa region. The region has about 1.5 million inhabitants mainly populated by the Wabena, the Wahehe, Wapangwa, Wakinga, Wasangu and Wasovi. Overall, Mbeya and Iringa region are densely populated and provide Tanzania with much of its food supplies; mainly maize, beans and potatoes. The third type of spirit healer is presented in a comparative study of four practitioners who practice in Ruvuma and Morogoro region. Ruvuma region has more than 1.1 million people and Morogoro region has nearly 1.8 million people. Much of the indigenous population of Morogoro region once lived in Ulanga valley and its surrounding highlands, notably the Wapogoro, Wangoni, Wanbwene, Wandamba, Wakinamanga, Wandendeuli, Wambunga, Wandwewe and Wangindo. The main crops of Mbeya, Iringa and Ruvuma region are maize and beans, while Morogoro region is known for cultivation of rice.

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15 The prefix Wa- refers in Kiswahili to a group of people also wa-nu, singular is M- derived from m-ntu or person. The prefix Ki- refers to the language of the Swahili, whilst the prefix U- refers to the country of domicile. Thus the Wanyihya speak Kinyihya and live in Umyihya country.
In the overview that follows, I describe some of the major historical events and circumstances to explain how *uganga* has been practiced before, during and after colonial days. Whenever appropriate or possible, special references are made to the Southern regions of Tanzania. More detailed information about the religious traditions of the three specific geographical areas, in particular the tribe(s) to which the expert healers belong, is provided in the respective chapters. In the course of this chapter, I will employ the concepts of ‘traditional’, ‘indigenous’ and ‘local’ medicine and healing freely in accordance with the way these are used in ongoing discourses. The broad definitions of cultural and therapeutic remedies and healing skills do not always concur with the views of my informants, who used a variety of definitions related to the concepts (see 1.2). For the sake of clarity, I have included in this chapter an overview of the present Kiswahili terms of Tanzanian specialists in *uganga*.

2.1 Migration and tribal wars in Tanzania: An historical outline

The Tanzanian people are composed of various groups, predominantly of Bantu origin. The word ‘Bantu’ (literally Ban-tu) is used to designate those people who inhabit the southern half of Africa and form a unit on account of speaking similar languages. The noun ‘ntu’ is plural for ‘muntu’ meaning a human being or a man. Although the Bantu languages are so similar, the Bantu are divided into various ethnic groups with different cultures and ways of living. It is generally believed that the Bantu came to East Africa from the Southeastern Congo Forest before 1000 A.D. in search of fertile soil for farming, and settled in Tanzania between 1000 and 1500 (see Okello Ayot 1976 and Tindall 1985). There were four clear migration movements of the Bantu into East Africa. These formed four groups of Bantu who settled in the North and North-West of Lake Victoria, in central and northern Tanzania, in coastal and highland areas and the southern areas. Most of the non-Bantu speaking people of East Africa originate from the Horn of Africa, Ethiopia, Sudan and the Nile Valley, like the Nilotics and the Cushites. Other ethnic groups originate from Central- and East Africa like the Hottentots, the Bushmen and the Pygmies.

2.1.1 The Ngoni invasion and the German occupation

The last group of Bantu to arrive in East Africa were the Ngoni (or Nguni). They had migrated from Southeast Africa in reaction to the Zulu expansion between 1820 and 1835. Fleeing from the Zulu, Ngoni arrived on the Ufipa Plateau in the Southwest of Tanzania as early as 1840, already incorporating refugees of plundered and defeated peoples (Brock 1966, Knight 1974 and Ebner 1987). Around 1845, the main body of the tribe split. Several groups went south to Malawi or the Congo, whereas others raided the north towards Lake Victoria. Another group moved eastward and from there, south along Lake Nyasa (Lake Malawi). In Tanzania, there were two groups of Ngoni who were each led by one chief. The groups usually outnumbered the people.
they fought against or they opposed groups too weak to resist them. In their search for land, the Ngoni worked out military tactics to conquer their enemies. The movement of the Ngoni became known as the famous mfecane, meaning ‘the time of troubles’. From the two Ngoni groups, five small, separate kingdoms were eventually formed. Three of them migrated to Zambia and Malawi and two of them remained in Tanzania. One group migrated to the North where they encountered the Nyamwezi, whom they attacked and defeated. This group settled in what today is called Tabora region. Around 1860, the Ngoni groups crossed the southwestern areas and faced strong Hehe warriors from Iringa region. In 1866 the Ngoni raided the present Southern regions Mbeya, Ruvuma, Iringa and the southern part of Morogoro. In the process they attacked and defeated the Sangu and the Hehe after which they settled in the present Ruvuma region.16 Whenever the Ngoni defeated their enemies, they forced the conquered people to join them (ibid.). In the southwestern regions the Wakiningamag17, who inhabited the hills to the west of the Ulanga valley in present day Morogoro region, united the Bena clans into a single fighting unit and extended their sphere of influence eastward. The Hehe in the west, and the Ngoni in the south, took this opportunity to invade and harass them in the western hills and drove them back into Ulanga valley. The highlands of the Uhehe lay to the south of main caravan routes. There was much trading and migration happened frequently between the tribes that lived in Ulanga valley (Morogoro region) and Njombe highlands (Iringa region). To secure the caravan routes, the Hehe formed a strong opposition to the Ngoni whom they drove off (cf. Redmayne 1968).

On the whole, the arrival of the Ngoni brought along drastic changes to Tanzania. In almost every place the Ngoni passed through, the invasion disrupted the daily lives and trade of people. As the Ngoni created chaos throughout the land, the population in East Africa - which had already been affected by the slave trade - decreased even more (ibid.: 17). The local peoples reacted by forming military states to stop the Ngoni people from expanding further, which eventually stimulated the creation of centralized military states in Tanzania. In a book about the history of the Ngoni Father Elzear Ebner (1987: 78-88), who was a missionary from 1930 till 1973 at the Benedictine Mission of Ruvuma, writes how the Ngoni raids took many lives and dislodged whole tribes and territories, as many people were taken prisoner by the Ngoni and were forced to live in Ngoni territory. Ebner states further that around 1875 various clans of the present Uhehe formed one tribe so as to match the Ngoni in strength and military power. This resulted in years of attacks by the Hehe on the Ngoni until a civil war between the Ngoni and the Hehe tribes broke out in 1884

16 The first group was called ‘Tuta’ and the second group ‘Gwangwara’.
17 Descendants of Manga. Wa = personal prefix(plural),-kini = from the line of.
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which lasted until the German occupation brought it to a halt (1885). Despite the initial success of the Hehe over the Ngoni, the war between them remained undecided as both sides appeared to be equal in strength.

According to Redmayne (1968: 37-58), the Hehe were influenced by the Sangu political and military organisation; using war medicine (amahomelo) to empower the warriors and a type of Kisangu speech to arouse the warriors before battle. Yet, many of these tactics were copied from the Ngoni. The devastation that resulted from continuous fighting lasted until the German occupation. By the end of the 19th century, the Bena clans were divided over the highlands west of Ulanga valley and those living within the valley. This occurred after the Germans attempted colonizing the area between 1885 and 1900. Because of the Ngoni’s continued attacks on other tribes, the German government decided to occupy the areas where the Ngoni had settled. The Ngoni knew the power of the Europeans and did not want to come into conflict with them. Once the military occupation was a fact, the Ngoni raids ended and the Ngoni began to live in relative peace with other tribes (Okello Ayot 1976: 126). On the other hand, the Hehe fiercely resented the presence of the Germans. The Germans attempted to subdue Hehe resistance between 1894 and 1898 and finally succeeded (ibid.: 159-165). In sum, the Ngoni and the Hehe were exceptional in the period of 1880-1900 regarding the size of their kingdoms and the impact of their military skills (cf. Redmayne 1968: 37-58).

The history that followed for the Ngoni and Hehe assimilated tribes of present day Iringa region mirrors the history of many of the Bantu tribes of Tanzania. Small independent chiefdoms were often under strain, in need of economic resources, which provoked the raiding of cattle. With kingdoms affected by dynastic politics, more and more new states were established in nearly empty areas. In these states, there were blacksmiths, priests and medical specialists. The Hehe assimilated with local tribes who lived together in large village settlements at the upper end of Ulanga Valley. They had a number of chiefdoms on a plateau, stretching between Iringa and Njombe in the South. During the second half of the 19th century, the Hehe and the Bena welded into two rival kingdoms, the Hehe under the Muyinga lineage, and the Bena under the Manga lineage. These kingdoms were once wealthy - their rulers had many wives, great herds, much cloth and ivory. Yet, it were the Hehe who were feared the most, as their warriors went out to raid cattle and also caravans with goods passing in the area around Mpwapwa (Morogoro region). By now, tremendous damage was done to Tanzanian societies as a result of the increase of the slave trade in West- and East Africa during the 18th and 19th century (see Tindall 1985). Next to the Arabs, who took a leading role in the trade, French and Portuguese were also active traders. The Hehe and the Ngoni tribes were among those indigenous groups that prospered
from slave raids, and also from raids of cattle or goods. Also in terms of cultural traditions from the north and the east of Tanzania the Hehe and Ngoni tribes took over various aspects. At the same time, the slave trade caused that more and more men got missing from the Hehe tribes, which reduced military force to withstand the Ngoni invasion. The already disrupted societies were damaged further by intense famines. The working load for women and elderly increased due to the slave trade and the many years of war (see Ranger and Kimambo 1972).

Generally, it can be concluded that the chaos brought by the Ngoni, together with the damage from the slave trade, and the occupation of the Germans has affected life to the present day in Tanzania: leading to fusion and diffusion of beliefs, practices and morals. Important for this study is the fact that Southern tribes incorporated a number of features from Ngoni cultures. One major impact came from the fact that the Ngoni were patrilineal, whereas quite a number of Southern tribes traced their descent bilaterally or matrilineally (Okello Ayot 1976: 162). Though many Southern tribes today are primarily patrilineal, aspects of matrilineity may still exist in their kinship organization.\(^\text{18}\) No doubt, the sufferings following the Ngoni invasion, the slave trade and the German occupation must have led to a great loss of confidence by the Bantu. The rebellions had been to a considerable extent a religious war to evict the white man. When the rebellions ended in defeat, the failure of the religious leaders was widely felt and the subsequent African attitude of awe and submission reflected the belief that the white men had a power superior to that of the tribal spirits. Tindall (1985: 175) mentions that many Africans must have reconciled themselves by thinking that their religious traditions were not powerful enough against Europeans. Others, disillusioned with tribal religion, turned in increasing numbers to Christianity. Here, in the rebellions, is the beginning of the slow process of erosion of tribal beliefs and customs which becomes an important theme during the next fifty years. In the course of this thesis I will frequently mention the role of this development in spirit affliction, healing and vocation.

### 2.2 Exchange of magical and healing traditions

Under the given situation, people all over the country were preoccupied with maintaining peace and obtaining prosperity. They needed an adequate food supply, good health, and children to carry themselves on into the next generation. The people were aware that such blessings were not available automatically, and that there were other dangers, such as droughts, famine and epidemic diseases. Since the bloody past had resulted in many deaths and serious losses, there was a scarcity of remaining elders, which meant that the cultural inheritance of the lineages was in danger. Many male

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\(^{18}\) In the case of matrilineity, the relationship is counted through males and females, whereas in patrilineal societies it is counted through males only.

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descendants were deprived of the knowledge on how to pass the tradition of customary lineage rites (mefundisho wa jadi ya ukoo) on to the next generation. The result being that the spiritual tie of people with their forefathers was under threat, leading to much uncertainty among men and women on how to secure procreation. Among the Southern patrilineal Bantu tribes, the spiritual tie with forefathers is of great importance, reflected in the characteristic organization of social relations. I will return to the intertwinement of social structure with spiritual ties in chapter three. Here I discuss more specifically what the impact of the Ngoni invasion brought with respect to exchanges of traditional customs in medicine and healing.

Ngoni diviners were known to be in contact with the spirits of ancestors. They were called either izamai (those who smell something) or abantu benlhloko (people of the dreams). Next to the ritual specialists, there were rainmakers, makers of war charms, or specialists in treating illness and epidemics. According to Waite (1992: 81), the main source of medical and healing traditions for the Ngoni came from therapeutic techniques of the Thonga, Shona, Chewa and the Tumbuka, who today live in countries neighbouring the Southwest of Tanzania. Read (1970: 179) gave the following description about the role of diviners in Ngoni kingdoms of Nyasaland (Malawi) from 1930.

In the Ngoni kingdoms, there were many kinds of specialists owing to the existence of several tribal groups, each with its traditional system of religion and magic, and each with varying methods of treating sickness, diagnosing the causes of misfortune, and interpreting omens and dreams... In times of national crisis the best diviners were called by the paramount chiefs ... The majority of diviners lived in relative seclusion, and had no outward signs of power in any political or economic sense, though in the past some of the prophets had also been warriors and leaders. Socially the diviners were always shown great honour when they came in response to a call, or when they went visiting on non-professional occasions.

Kings and chiefs among the Ngoni used to control abuses by the various practitioners, who could be consulted for army strategies or accusations of sorcery or witchcraft. Abuse could be dealt with by means of paying relatives of a victim, or by bringing the convicted to court. Sometimes the convicted practitioner was sentenced to death. The fact that political authorities were involved in regulating healers in cases of sovereignty, may well have been a general feature of African kingdoms. Pre-colonial medicine and healing took place in alliance with chiefs and elders, but local healers also exerted influence on health issues and on environmental and geographical issues. In Shamba society for instance, healers were consulted in the selection of village sites, health quarantines and the conviction of alleged witches in a community (Feierman 1986: 208).19

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19 For the general history of the Shamba kingdom see Feierman 1974.
In contrast to the diviners and healers of the Ngoni kingdoms, the Hehe kingdoms had incorporated medical and healing traditions from the Pogoro, Sangu, Ndamba, Mbunga, Bena, Ndewee and Ngindo. Many of these tribes were probably original Bantu speakers who settled in south-central Morogoro region, known as Kilombero Valley and Ulanga area, which lie close to the border with what is now Iringa region. The chiefs (vatwa sing. mutwa) had special relationships with the spirits of deceased chiefs. They made offerings on their graves to ask for assistance in matters which concerned the whole chiefdom. In fact, the Hehe were reputed for their specialists in rainmaking, and so were the Ndewee. The speciality of the Mbunga and the Ngindo lay in identifying witchcraft and sorcery. The homeland of the Mbunga and the Ngindo was originally Ruvuma region that had become Ungoni country. The tribes of Ulanga area exchanged techniques of divination, healing and magic that were adopted by people in Kilombero valley. Among the various tribes, the Ndewee spirit mediums, called Wambuyi (singular Mbuyi), were valued also for their military prediction skills. According to Waite (1992), the Wambuyi were territorially based in and around the Kilombero valley in Tanzania. Certain clans monopolized the position of the Wambuyi spirits, giving way to its heritage in next generations. The Wambuyi spirit mediums were also responsible for maintaining customary religious rituals. Herbal knowledge was the domain of another group of spirit mediums among the Ndewee.

The Mbunga and the Ndewee were active traders in the nineteenth century and in both tribes this role was reflected in the propitiation ceremonies. Like the Ngoni and the Hehe, the Mbunga participated in the East African slave trade and conducted raids up to the coast of Dar es Salaam. From the cultural exchanges, innovations took place between coastal and local practices in terms of divination, spirits and spirit possession. Some Mbunga converted to Islam, the religion of the Swahili and Arabs along the coast. In the course of the tribal wars, the spiritual guidance from the Wambuyi spirits was strengthened with the emergence of another group of territorial spirits among the Ulanga tribes, called the Kihami spirits. The Kihami were considered nature spirits of the Ndewee who had magical skills. In fact, the Kihami spirits became a major force behind the emergence of healing and anti-witchcraft practices among the original Ulanga tribes. Besides the Ndewee, the Kihami also guided mediums among the Mdamba, the Mbunga and the Ngindo. They did so together with the traditional (family- and lineage ancestral) spirits, while also coastal spirits could inspire these spirit mediums. I will come back to the role of Kihami healing practices from Ulanga in chapter eleven.

Some traditional concepts and practices of religion, health, and magic were shared throughout the regions where Eastern Bantu languages were spoken, as indicated by vocabulary terms. Within the context of history also the use of the concept ngoma
1.4) should be explained. According to Janzen (1992: 12 and 88), the word ngoma originally derived from South African Ngoni speaking groups. Therapeutic practitioners among the Ngoni who used ngoma were called the isa-ngoma. They would employ the therapeutic idiom when ceremonies, initiations, or rites of other kinds were encompassed. Other terms, according to Waite (1992: 23-27), were ‘medicine’ (dawa plural madawa), ‘doctor’ (mganga plural waganga), ‘ancestor spirit’ (mzimu plural mizimu) and ‘ceremonial offering’ (tambiko plural matambiko). Anything that would facilitate healing or uganga could be called dawa. In sum, uganga would capture at the same time, the substances (ingredients like dawa), and the artistic characteristics (acts like ngoma and tambiko) that were involved in the healing profession. Treatments with dawa would involve remedies made from leaves, bark, roots, and sap of trees and shrubs, also ‘medicine from the tree in the fields’ or dawa ya mti shamba (mti means tree with the root –ti). The waganga knew of a variety of plants some of which are still used today for identical medical and ritual purposes and with identical names. For certain ailments, the modes of treatment have probably remained stable over many centuries. The proto Bantu concept kuganga (see 1.1) was and still is used together with the verb kuponya or kupona, meaning ‘to become cool, become well, or cured’ but also ‘to become safe, be rescued, regain strength and recover health’. In an attempt to seek the deep historical roots of ngoma, Janzen (1992:63-64) connected ku-ponya/pona with ngoma therapeutics, because of its metaphorical use with regard to the religious experiences that people have with spirit forces. Another Bantu word aligning with kuganga is kutibu meaning ‘to treat medically’. This form of healing refers in particular to the use of material means such as plants (see Blokland 2000: 12-38). In the practice of spirit healers today, the materialistic and the artistic are still strongly interwoven.

When the traditional Bantu would speak of spirits, they meant in the first place the ancestral spirits or mizimu (singl. mzimu) from the reconstructive root -dimu meaning ‘shadow’. The mizimu are till today differentiated in family, lineage/clan, territorial, ancient or foreign ancestral spirits. Ancestors can appear as snakes, mahoka or masoka, living mainly in caves. Related to the mizimu are the spirit propitiations by means of ceremonial offerings (matambiko sing. tambiko). Tambiko involves prayer (kuteta) together with gifts (sadaka) to ancestral spirits. An offering is locally brewed beer or flour, the spitting of water and the sacrifice of an animal, normally performed by the eldest member of the family. Propitiation was/is carried out at specific places, like trees and other natural features in the landscape. These places also used to be the preferred sites for traditional shrines, but today there are few. Prayers in burial ceremonies placated the spirit of the deceased so as to reduce the chance that the spirit
would harm anyone out of anger. With the coming of Arabs and Europeans, various new spirits entered the domain of traditional religion. What this entailed is further discussed in chapter three.

Whenever the Bantu referred to practices of malice coming from persons by means of sorcery or witchcraft, they would speak of uchawi. In historical times, sorcery and witchcraft would be controlled through ordeals or by waganga, who used the inspiration from their own spirits to detect the culprit. A generic name for ordeals, mwavi, is still found in large parts of Bantu-speaking Africa today. Some mwavi were made from fire or hot water to identify thieves, murderers, adulterers; but not sorcerers. According to Waite (1992), mwavi used to be applied for sorcery control also, but says that evidence is inconclusive. I know from oral information that the poison ordeal in Tanzania has been used until it became prohibited by the German and later the British administration. Until today, acts of sorcery imply the manipulation of spiritual and natural forces for bad purposes. The verbs kulowa or kulogwa refer mainly to acts of witchcraft. Uchawi or ulazi are nouns to indicate a malevolent power inherent to a person. This power may be inherited, thus being latent by birth, or, the power may be passed on either by a parent or another witch. Witches (wa-chawi sing. mchawi) may use sorcery (black magic). In principle, sorcery can be taught to anyone. Because witches are usually the ones to perform sorcery, the concept of uchawi is commonly in use when referring to either of these practices. Those specialists who practice white magic may be distinguished by the name wanawanga (sing. wanga). The word refers to mwanga or ‘light’, in the sense that those are people who are guided by spirits to do magic without bringing harm to others. In chapter three I will come back to the various magical and healing traditions that encompass spirits, religious ceremonies, witchcraft and sorcery.

2.3 ‘Uganga’ in the colonial period

By the Anglo-German Agreement of 1889, Germany was given control of the area round the north end of Lake Malawi and east of Lake Tanganyika (Tindall 1985: 178-179). The British secured some of the land between the lakes. During the German protectorate, African healers whose authority was a threat to their sovereignty were prosecuted; leading to the killing of various healers. Feierman (1986: 207-208) wrote how the Germans systematically destroyed the control of Shambaa healers in the Northeast over the conditions of health, except for those few forms that could be hidden from exposure. For the Shambaa the consequences were that more sicknesses evolved with

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20 The act of prayer in burial rites is common among the Bantu and many terms exist in Bantu languages (cf. Waite 1992: 25).
disastrous effects for the population. In 1890, huge irrigated areas in the Tanzanian Usambara Mountains of Lushoto district had dried up when German planters occupied the land of present Tanga region. The Germans forced the indigenous Shamba people to work in malaria areas that were normally avoided. Labour division also changed. With men away as slaves, or as labourers working for the Germans, mainly women and elderly people had to ensure food production (ibid.: 213). Since the colonial system had placed the burdens of food production on women without providing them with substantial help in medical care, the German government had encouraged missionaries to fill the gaps left by government medicine. Yet, this only covered the urban centres and failed to succeed due to the two World Wars ahead.

In other parts of the protectorate, the Germans exerted less drastic changes, as they did not settle there in large numbers. German colonial presence was, however, felt by all peoples including the Hehe and Ngoni tribes. The waganga in the South were harassed for fear that they would be instigators of riots and rebellions such as the Maji Maji revolt of 1905-1907. The notorious ‘Maji-Maji’ revolt was lead by a Hehe chief who took the Germans completely by surprise. The word maji means water and it was reported that a medicine man, taking the form of a monster living in the Rufiji River, dispensed a medicine - a mixture of maize, water and sorghum seed - which afforded protection against disease, famine, and every other sort of evil, if taken internally or sprinkled on the person. The message also spread that this medicine turned bullets, fired from a European rifle, into water. The Maji-Maji rebellion was crushed by the Germans which proved that the message was untrue. A terrible act of vengeance started. All villages in the Southeast of the country that had taken part in the revolt had their huts and crops destroyed by the Germans. Records mention the loss of over more than 100,000 lives (see Redmayne 1968, Ebner 1987).

In 1909, the Germans began to regulate the healers through district officers who issued certificates specifying the illnesses that were treated, the prices that were charged, and the location of the practice. Some years later, when the Germans had stopped all inter-tribal warfare in the protectorate, World War I erupted (1914). That same year, the protectorate became one of the war zones. The whole area suffered devastation from the fighting between the Germans and the British, the latter aided by Indian and South African troops. Eventually, the British took over control and divided the area by the new name of Tanganyika into eleven provinces. Though

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21 According to an oral narrative recorded by Feierman in 1967 (1986: 208), the sicknesses of the period were interpreted as punishment meted out by the conquerors to ensure obedience of the Shambaa.

22 The chief was a Hehe called Mkwawa, yet the Hehe tribe did not take part in this war.

23 The name Tanganyika was derived from the northeastern regional name Tanga.
colonial policies differed from time to time, on the whole, the colonialists did not want *uganga* to intervene in matters of sovereignty or public order. Under the British, the Witchcraft Ordinance of 1922 made it illegal for anyone to practice *uganga* with the intent to use, or counter-act, witchcraft. In 1925, the British instituted a policy of indirect rule through hereditary chiefs. The British intention was to use chiefs in order to win the loyalty of their subjects. Yet, in terms of indigenous health care, the implication of Indirect Rule was that only the practice of making rain was allowed to continue. Virtually all other forms of indigenous practices in *uganga* were rejected, as these were believed to encompass some form of magic or witchcraft.

Overall, the breakdown of collective African control over the health arena had disastrous effects, not in the least because control of witchcraft and sorcery had become illegal. At that time, chiefs and healers lost much of their power to combat anti-social behaviour. Yet, anti-witchcraft practitioners appeared all across Tanganyika during the years of British rule (1919-1961). These practitioners were experts in finding witches, or in protecting the innocent. The Government’s response was ambivalent. On the one hand, there was fear that witch-finding movements, which spread rapidly across district boundaries, could be the basis of large-scale rebellions (Ranger 1966: 6). On the other hand, local administrators sometimes welcomed the use of witch-finders to restore peace in a community. By 1930, however, the British authorities had become more interested in the nature and underlying philosophy of what was called native medicines. Lord Hailey, an expert on ‘native affairs’ thought of registering traditional healers so as to favour incorporation of traditional with modern medicine in 1933 (cf. Mesaki 1998, Beck 1981). Hailey, who by 1939 had made an African survey on indigenous healing practices, had yielded that not all *waganga* were involved in witchcraft. From that time onwards, interest in *uganga* was aroused to check upon its character and usefulness which lead to a steady growth in the activities of *waganga* during British colonial rule. At the time, the British placed the practice of the *waganga* under Cap. 92.20 of The Medical Practitioners and Dentists Ordinance. It said (cf. Swantz 1990: 12):

Nothing contained in this ordinance shall be construed to prohibit, or prevent the practice of systems of therapeutics, according to native methods by persons recognized in the community to which they belong and who are duly trained in such a practice.

As *uganga* developed during the British era the colonial administration did not interfere with practices of *uganga* unless practices lead to murder. In brief, as Beck (1981: 71-73) cites, British policy on indigenous health care had evolved from one of ‘benevolent neglect’ to that of ‘tolerance’. Consequently between 1930 and 1950, dispensaries and government hospitals coexisted together with the practices of the

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24 In *The Laws of Tanganyika* (1947).
According to Waite (1992: 98), African health care continued to rely on social laws and on spiritual forces to explain and control events and relationships. Even when much of the authority over communal affairs was lost, many local healing traditions in the country survived the colonial period. However, healing practices had become more directed to preventive and curative aspects and were less concerned with general social conditions (Feierman 1986: 207-209). Traditionally, the genuine African healer had no counterpart in Europe because of the many roles that the *mganga* played in the community (see Gelfand 1964).

### 2.4 The situation after independence

Two years after independence, in 1963, the new government was placed under the Tanganyika African National Union (TANU) which was lead by Julius Nyerere (see Barkan and Okumu 1979). As the TANU prepared for a democratic one-party state, they replaced traditional chiefs all over the country with appointed officials. Due to the abolition of ‘traditional leadership’, local control and measures to maintain harmony in the communities got lost while people relied less and less on their traditional institutions (Tanner 1970: 39). The ordinary man could not rely on the agencies of the government either, so in case of trouble self-help was the only solution. At that time, according to Mesaki (1998), the health situation in Tanzania was in a bad state as there were only 12 Tanzanian doctors staffing the hospital services. In 1978, Primary Health Care in Tanzania began to develop. To meet the shortage of modern trained health staff, over 6000 village health workers were trained to bring basic health care and modern medicines to rural communities. The training and promotion of modern medicine took place during the villagization program in the mid 1970s, also called operation *Sogeza* under which people were to live in concentrated settlements. In some of these settlements were later classified as *Ujamaa* villages. According to Feierman (1986: 214), the creation of *Ujamaa* villages as legal instruments of socialism and development, made it possible for people to have a significant impact on their own conditions of health for the first time since the German conquest. The value of voluntary villages as creative institutions was obscured by the disruptions due to forced villagization in some regions. This situation resulted in a change of District Policy with regard to healers who were anti-witch specialists. *Waganga* were discouraged from visiting villages where collective cultivation had been imposed. In fact, permission to travel within the district was interdicted to the healers. Due to lack of supervision by the government, the strategy to bring basic health care by village health workers failed.

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*In Southwestern Tanzania, operation *Sogeza* took place in 1974. From local sources I learned that the operation did not force renowned *waganga* to move into nucleated villages.*
What went ‘wrong’ since the late 1970’s in Tanzania has been amply documented and analysed. Yet, according to Swantz and Tripp (1996:1), much went ‘right’ as well. Many good intentions were at the bases of the political structure as the country implemented universal primary education and adult education programs that succeeded in substantially reducing illiteracy. Also, the leadership attempted to prevent factionalism based on ethnicity or religious affiliation. Emphasis was on national unity focused around the Kiswahili language. The brand of socialism in Tanzania, introduced by Julius Nyerere, drew the attention of states, donors, international organizations, movements and individuals who were attracted by the emphasis on equality, people’s participation in decision-making, self-reliance, and providing basic needs. Indeed, Tanzania was a leader in creating a public health program even before the World Health Organization had identified Primary Health Care as an international strategy.\footnote{I draw in part from the SAREC report by Simeon Mesaki (1998) about the changing role of traditional medicine and healing in Dar es Salaam between 1970 and 1990.} In short, Tanzania had created a favourable social climate of development even if much of the structural adjustments failed due to an economic crisis in the eighties.\footnote{See also www.tarcaoiago.tz/humman.html.}

In the meantime, western biomedicine had evolved into a truly cosmopolitan medicine and spread to virtually all parts of Africa. The African governments had adopted it as the official health care service, which in most cases means the only health care service provided with public funding. Despite the phenomenal growth in modern medicine in Tanzania, the doctor to patient ratio in 1997 was 1 to 22.716. This ratio should be seen in the light of a large medical staff trained to carry out several tasks of doctors. Hospital services were and still often are distant for rural inhabitants. In June 1997, Tanzania had 195 hospitals, 302 health centers and 3,577 dispensaries.\footnote{According to the website http://www.tanzania.go.tz/population.html on 16-9-2002, the numbers of health care services have somewhat increased in 2000. Considering the high increase of the population in some areas there is, however, little change in facility/population ratio.} The positive development is that the dispensaries serve over 8000 villages (cf. Mesaki 1998). Still, the development in African modern health care in Tanzania should be seen in a broader context of man’s interaction with disease through health-seeking behavior, characterized by a multi-faceted users pattern. People’s pursuit of health and healing takes place at the interface between, on the one hand, modern or cosmopolitan clinical medicine, and a variety of alternatives on the other. Next to self-medication are the services of the traditional healers, among them midwives, diviners, spirit- and faith healers and herbalists, there are the Chinese and Indian practitioners mainly working in urban areas.

Users of public health care tend to take modern drugs or plant remedies to treat the natural etiology of an illness manifested in purely biological manifestations. Yet, many
people in Tanzania who use modern (cosmopolitan) medicine do not regard disease solely as a biological state, with a focus on the physical body. Many users share perceptions that are steeped in social, psychological and spiritual paradigms, which to them are as important as the physical condition (Katz and Kimani 1982). The spiritual paradigms take their references from indigenous concepts of health and illness, ascribing the cause of an illness or discomfort to spiritual forces arising from angered ancestor spirits, evil spirits, or the effect of witchcraft, also referred to as African diseases or disorders (see 1.2). Western biomedicine does not have answers to spiritual occurrences of this kind and thus offers no solutions. The reason is that illnesses or disorders of an African etiology are often complex due to socio-cultural factors.

According to Katz and Kimani (ibid.), diagnosis, divination and therapeutic practices of *uganga* in much of East- and Central Africa, allow for both naturalistic explanations as well as for human-caused, and spirit-related afflictions and cures. Those *waganga* who not only supply herbal or animal remedies, but also take measures against supposed enemy’s charms, curses, aggrieved ancestors, evil spirits, and hostile witches, need inspiration and protection by their spirit(s) so as to intercede between the people and the supernatural. For this purpose, they may 1) recite incantations to neutralize adversities; 2) advise village or family elders about rituals, taboos and counter-magic; 3) make offerings to appease ancestral spirits or provide protective means or medicine for clients. Tanzanian communities, however, differ considerably in their cultural entities and beliefs in disease and health perceptions. For this reason, clients may prefer the services of *waganga* who share the same ethnic origins. In rural areas, many *waganga* are peasants who work part-time in their role as diviner and/or healer and herbalist. The very popular healers are available full-time for their clients. Besides factors of a cultural, social and political nature, economic and emotional factors need to be considered. For instance, many Tanzanians in rural areas do not always have access to money. They may, however, find indigenous healers prepared to treat free of charge or they may render services to the healer to pay for treatment. Although the perceptions of the cause of an illness or disorder influences health seeking behaviour in clients, previous experiences and efforts to seek a cure or an improvement of wellbeing need to be taken into account. Many clients are often disappointed about their experiences with modern health care. Several studies have shown that people in East- and Central Africa are not happy with modern health care (Katz and Kimani 1982, Ojanuga 1981 and Leshari 1984). Some of the most common reasons for dissatisfaction are:

- Hospitals are too far away in case of urgent treatment.
- Long waiting time in urban hospitals or rural clinics.
- Short appointments with doctors or hospital staff.
- Feelings of confusion and being alone in an unfamiliar environment.
- Having little opportunity to express one's own concerns or fears.
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- Little or no concern for psycho-social context of disease.
- Misunderstandings between medical staff and patients about disease concepts.
- To obtain medicine without any explanation as to the cause of the illness and without a prescription of the drug.
- To leave without the proper medicine due to a lack of provision.

The factors as outlined suggest that after independence traditional health care has remained very important in Tanzania. It is practiced extensively and has tacit recognition of the Tanzanian government. Estimations are that Tanzania has currently about 75,000 traditional health care practitioners, exemplifying a ratio of practitioners/peoples population of 1 to 400 (cf. Mhame 2003). Given that only a part of the practitioners are nationally registered, there is reason to assume that many more traditional healers are active. In a country with a population of an estimated 34 million (2002 census), 80% of whom live in rural areas, access to traditional healers is thus fairly easy. Problems may arise, however, when a specialist healer is needed. In sum, the justifiable claim that modern medicine has been socially and politically adopted and accepted should be understood in reference to the use of its therapeutic resources and not necessarily to the acceptance of its cognitive principles (see Foster and Anderson 1978, Kleinman 1980, Helman 1984). Mesaki and a number of African scholars state further that indigenous healing practices urgently need to be judged for their merits, since modern medicine cannot sufficiently compete with the incidences of illness in Africa. What is the role and status of traditional health care in Tanzania today and how are promotion, organization, and policy-making arranged?

2.5 The promotion and organization of ‘uganga’

2.5.1 Political incentives

The World Health Organization has been engaged in programs to integrate the biomedical with the indigenous health system, in order to provide more realistic, efficient, and cheaper health care for developing countries. This integration is considered crucial, since nearly 80% of the population live in rural areas and depend on the facilities of indigenous healers. In 1978, a report came out from the World Health Organization (WHO) based on a conference held in 1977 in Geneva, called ‘On the promotion and development of traditional medicine’ (1978a). Participants had formulated that traditional health care is an affair of the traditional healers and those who officially represent them. For reasons of efficiency, it was considered best that the present potential be addressed.

29 I refer to a document distributed on the Phytomedica Network on April 24, 2003 by Dr. P. Mhame of the National Institute for Medical Research in Dar es Salaam.

30 I also refer to a paper by Debie LeBeau, Lecturer in Sociology at the University of Namibia at Windhoek, distributed on the Phytomedica Network on November 11, 2002.
The 1978 Alma Ata Declaration on Primary Health Care (of Health for all by the year 2000) in the nineteen eighties became an important impetus in Tanzania to address the failure of the socialist government to set up a Primary Health Care scheme in the seventies (2.4). Participants of 134 nations, including some of the heads of African states, recognized the relevance of traditional and indigenous health care providers in public health (cf. v.d. Wolputte 1997: 48-68). Since the Alma Ata Declaration, the WHO (1978b) has slowly pushed for the promotion, incorporation and modernization of African medicine and healing giving it an official place in the cultural heritage within national health care (Akarele 1987). The mentioned attempt stemmed from the collaboration of western and traditional medicine in China and in reaction to the narrow approach of western medicine with its technological and disease orientation (cf. Mesaki 1998). Attempts have been made in African countries to better evaluate indigenous medicine and healing. The IDRC (International Development Research Centre of Canada) and the World Bank have funded research in some cases. New research institutes were created throughout Africa, though some were already in existence. Their focus, however, was not so much on enlarging the understanding of traditional health care, nor did they actively collaborate with its representatives. Much along the line of Western scientific thought, their main research focus was on botanical knowledge and medicinal plants. I will return to this feature later.

In Tanzania, as in many countries in the South, there has always been some form of resistance (bureaucratically or sociologically) to actively involve traditional healers in the national health care system (see Pillsbury 1982, Velimirovic 1984). According to Bichman (1979: 178), programs of 'integration' of traditional and modern medicine were introduced; but merely established the superiority of modern medicine by supervising the activities of traditional practitioners. Not many healers were prepared to accept this situation, as the social status of the healer within his/her given culture was often higher than achieving recognition by a public health administration, that regard the traditional healer as an auxiliary to national health care (see Van der Geest 1985, 1987, Ventervogel 1996, v.d. Wolputte 1997). Whenever Governments in Africa would utilize indigenous specialists, these often concerned midwives who participated in health and family planning programs. Up until today, few African countries have done systematic research on the varied indigenous practices. How has the mentioned process taken effect on the organization of uganga in Tanzania?

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31 An example comes from Ghana in 1979 with a program called the Primary Health Training for Indigenous Healers (PRHETH). In general the healers were willing to cooperate, yet the western trained health staff had objections to participate as they regarded the skills of the healers as inferior (cf. v.d. Wolputte 1997: 66).
2.5.2 Registration and the quest of legislation

Following the 1978 attempt to facilitate the evaluation of traditional health care in Africa, two important factors ought to be mentioned with regard to Tanzania. First of all, traditional healing practices had been placed under the authority of the Ministry of Arts, Education and Culture in Tanzania. This meant that registration took place at cultural offices throughout the country providing the waganga with official permits, known as vibali (sing. kibali). The waganga were not prohibited from practicing under Tanzanian laws, but they did practice under legislation that dates back to British rule (2.3). There was a lack of legal foundations for local medical and healing practices. Various attempts to organize the waganga had been met with difficulty (Janzen 1992: 170). In 1971, for instance, the National Union of Traditional Healers (Umoja wa Waganga Tanzania – UWATA) was formed. Semali (1986: 87) cites that the union had a brief and troubled life, which according to Mesaki (1998), was due to lack of effective leadership. In the eighties, a centralized organization came into being in Tanzania by the name of Shirika la Madawa ya Kiasili or The Organization of Traditional Medicine, which was the first body to receive official recognition by the Ministry of Arts, Education and Culture. Yet, this organization also did not last very long.

The second factor - with regard to the position of traditional practices in Tanzania - is the role played by the Muhimbili Traditional Medicine Unit (MTMU) in Dar es Salaam. This unit was erected in 1974 by the Faculty of Medicine and incorporated in the College for Health Sciences, a national hospital and the nucleus of the Muhimbili University College for Health Sciences (MUCHS). The unit changed its name in The Institute of Traditional Medicine (ITM) and, up till today, is considered the only official body of recognition for traditional healers. To my knowledge, and that of Mesaki’s (1998), many waganga have been disappointed with the input of the Institute. The waganga in and around Dar es Salaam had hoped that the Institute would collaborate in the crusade for legal authorization, but in reality the people at the Institute dedicate themselves mainly to research on the botanical, pharmacological and clinical evaluation of local medicines. For this purpose, employees gathered information and plant material from waganga in various parts of the country. They also grew medicinal and aromatic plants on experimental farms to test them for commercial use. A herbarium was erected in the course of this process.

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32 This measure sprung from the Ujamaa period in the seventies.
33 Ever since the seventies, the Institute of Traditional Medicine has published a good number of articles on ethnopharmacology and ethnobotany. See also the Proceedings of the International Conference on Traditional Medicinal Plants that took place in Arusha in 1990.
34 These were mainly well known (European) plants on which many records were already available.
In 1980, after the WHO had recommended that African countries bring traditional medicine under the authority of the Ministry of Health, the National Health Care policy of the government of Tanzania formally recognized the role played by traditional healers in the delivery of health care to people. The Minister of Health in Tanzania made clear statements about the status and importance of Traditional Health Care Practice (THCP) and announced to take appropriate steps to regulate and formalize THCP. In some neighbouring countries, like Zimbabwe, the formation of the ‘Zimbabwe National Traditional Healers Association’ (ZINATHA) and the passage of the 1981 Traditional Medical Practitioners Council Act were already significant steps forward toward the professionalisation of traditional medicine (Last & Chavunduka 1986; Chavunduka 1994). In 1986, an International Conference was held in Arusha, Tanzania, to consider how traditional medicine be incorporated in the delivery of primary health care. A follow up took place in 1990 with the International conference on Traditional Medicinal Plants, also held in Arusha. In between both conferences, Tanzania prepared for a National Traditional Health Care Policy and carried out studies to determine the attitude and knowledge of traditional healers and birth attendants on modern health care and to check on the utilization patterns of traditional medicine by the rural population of Tanzania. This study was carried out in 1985/86 by institutions of Dar es Salaam University and received funding from IDRC. (see 2.5.1). In the meantime in Malawi the International Traditional Medicines Council (ITMCM) was formed in 1995, and in 1996, launched its activities including the establishment of a medicinal botanic garden and the industrial cultivation of medicinal and aromatic plants. The organizations in Zimbabwe and Malawi are founding members of the International Organization of Traditional and Medical Practitioners and Researchers that currently has its secretariat in Bulawayo, Zimbabwe. The international organization develops and promotes African traditional medicine by the regulation, production and standardization of herbal remedies, but also, by upholding culture and tradition in the context of change and modernization (see LeBeau 2002, Mudida 2002 and Kambewankako 2002).

By 1990, a minor department at the Ministry of Health was erected in Dar es Salaam for which only two persons were appointed to formulate the new policy of Traditional Health Care, which was to be officially announced in 1991. In order to formulate the policy, coordination and organization was needed with respect to the activities of traditional healers. At the request of the Ministry of Health, the current organization of healers formed in 1994 under the name The National Organization of Traditional Healers and Midwives in Tanzania (Chama cha Waganga na Wakunga wa Tiba ya Asili

35 See Yesetsani Kambewankako, director of the ITMCM in Blantyre, Malawi in a paper distributed on October 28, 2002 by the Phytomedica Network (phytomedica@yahooogroups.com).
This organization became registered under the Societies Ordinance, another remnant of colonial laws, through the Ministry of Home Affairs.

2.5.3 ‘Ngoma’ and a centralized organization

In the eighties, when Janzen (1992) was in Tanzania to conduct his research on ngoma (see 1.4), he wondered why traditional and indigenous medicine and healing, notably therapeutic rituals of music and dancing were controlled under the Ministry of Arts, Education and Culture and not under the Ministry of Health. He found that ngoma was a predominant factor in coastal areas of Tanzania, encompassing entertainment as well as healing:

[In Dar es Salaam] the term ngoma is widely recognized as connoting performance, drumming, dancing, celebration, and ritual therapy. This understanding of ngoma means that the performances are independent of the healing functions, leading to the distinction between ngoma of entertainment and of healing (1992:21).

Janzen refers to the first type of ngoma as ‘secular ngoma’ to distinguish from so-called ‘real’ healing ngoma’s. Some of these ‘secular’ or popular ngoma were organized by the National Service in an effort to connect the state to the powerful symbolism of socially focused song-dance. The various forms of therapeutic ngoma were seen as adjacent. According to Janzen, the Shirika la Madawa ya Kiasili (The Organization of Traditional Medicine) that was formed in the eighties, functioned as an umbrella organization of therapeutic ngoma, dealing with some of the same issues as the entertainment ngoma. All forms of ngoma involved individuals and families who made their living from these performances. Since ngoma was so commonly in use in healing practices along the Swahili coast, it was considered a typical cultural feature of all traditional and indigenous health care practices in the country. Subsequently, all forms of uganga were given in the care of the Ministry of Arts, Education and Culture. The concept of ngoma therapeutics not only unwillingly created a stereotype view on uganga practices it also made government representatives address mainly its cultural properties. Medical or therapeutic dimensions of divination, ritual therapy, and musical sessions, were largely ignored. Since both healing ngoma’s and spirit afflictions were seen by government officials and scientists as a sign of backwardness - identified with life in the rural areas - little attention went to its role in Tanzanian society. With increasing numbers of urban Tanzanians dismissing ngoma-healing methods, the healers also began to reduce their ritual and musical activities.

Today, whenever a ngoma is held, this happens either in a small backyard or room of the house where the healer lived. Because quite a number of people normally participate in a healing ngoma, the urban conditions render less success than in rural areas. Furthermore, the musicians and assistants who make up part of the ngoma-healing sessions need to be warned some time ahead and are paid for their contribution. In other
words, *ngoma* in urban areas means a more difficult and costly intervention that can only occasionally be carried out, whereas in rural areas, it can take place outside at any given time and free of charge. As a consequence, a good number of urban practitioners have moved to the outskirts of the city where they find more space as well as support from locals. Here also spontaneous (daily) sessions are possible, provided that the healers dispose of a large compound. These are still very few. The changes to have taken place in *ngoma* therapeutics over the past decennia do certainly not imply that urban coastal people suffer less spirit afflictions or disorders than do rural people. Though modern education reduces some traditional beliefs and practices, the rise of urbanization has not stopped the presence of spiritual afflictions. In fact, people increasingly seem troubled by ‘modern and foreign spirits’ that demand expensive objects and excessive rituals. Many of those clients will seek treatment with healers outside the urban center. The different developments between the urban and rural areas also have repercussions in the organization of the traditional healers.

### 2.5.4 The national healer's organization CHAWATIATA

Between 1994 and 2001, I have been in contact with two popular spirit healers in Dar es Salaam, both much involved in the struggle for recognition of traditional health care. One is a male healer called N’hombar Ijamasallah, a Sukuma healer of around 47 years old with ancestral, Arab and Swahili spirits. He has been the initiator of the Zanzibar Traditional Healers Organization. Upon request of the Zanzibar Ministry of Health, he has also set up the organization for the Tanzania mainland. In 1994 N’hombar Ijamasallah introduced me to a female healer, a relative of him, called Nuru Nhanga’chalalo. She is Nyamwezi, about 42 years old and a renowned spirit healer in Dar es Salaam (see preface). After N’hombar left the organization, Nuru became a representative of the mainland healers organization called *Chama cha Waganga na Wakunga wa Jadi za Taifa Tanzania* (The National Association for Traditional Healers and Midwives), briefly known as CHAWATIATA. She also introduced me to various members of the Association who practice in Dar es Salaam, which allowed me to observe how the healers in urban settings operated.

The initiators and representatives of the CHAWATIATA, whose seat is in Dar es Salaam, are in regular contact with the Ministry of Health in seeking improvement of the status of THCP. Ever since the activities of this organization started in 1994 until 2000, I have followed their moves. Until today, the compulsory registration of the organization with the Ministry of Home Affairs stands in the way of an official recognition by the Ministry of Health. This is a matter of great frustration to the members of the organization. Nonetheless, CHAWATIATA is considered to be the only regulative body under which the *waganga* (healers) and *wakunga* (midwives) are allowed to practice. Each member pays a small annual fee and is given a membership...
card after having given proof of his or her skills. Travelling waganga who render services away from home, or waganga who wish to start an indigenous clinic, need to ask permission from CHAWATIATA. The main goals of the organization are:

- To coordinate all traditional healers using traditional means to improve the well being of the people.
- To protect, promote, maintain and increase the general knowledge of services provided in traditional health care.
- To ensure that regulations in traditional healing and medicine are maintained.
- To ensure that every member fulfils his duties and activities with openness, freedom and in the interest of social wellbeing in public health.
- To reunite traditional healers and to bring them in contact with modern doctors through meetings and discourses and to enhance the exchange of views and knowledge to clear any misunderstandings between them.
- To protect the rights and gains of the members as well as that of the clients who should be informed of the merits and advantages of traditional medicine and healing.
- To ensure research in cooperation with the government and other organizations so as to promote traditional medicine and healing.
- To protect and recognize the rights of origin of the medicines on which research is done and to check on any misuse out of greediness or dishonesty.
- To control all activities concerning traditional medicine and healing and expose all its activities to the government.
- To improve the usage of traditional medicine and healing and coordinate activities involving storage, cultivation and preparation of herbal medicines.

Unfortunately, the aims of CHAWATIATA are endangered due to a number of reasons. Let me mention three of them. First, it is said that there is inadequate leadership. The chairman of CHAWATIATA is a salesman of herbal medicine and has no healing skills. He was, however, the only person who was ready to accept the voluntary position of chairman. Secondly, there is a disparate representation of practitioners, both in terms of skill and gender. Most members of the organization are males working in urban areas. To meet with the demands of the urban clientele, most of them work primarily as herbalists. The fact that a majority of representatives of CHAWATIATA are men does not reflect the reality, as many practitioners of traditional medicine and/or healing are females. Furthermore, the role of herbalists (waganga wa mti shamba), spirit healers (waganga wa pemo) and midwives (wakunga) differs considerably. CHAWATIATA incorporates a broad range of traditional practices that brings together various practitioners who may appeal to clientele, each with their own wishes and needs (see 2.7). In rural areas, some traditional health representatives assemble the various roles in one. These are often reputed healers who run traditional healing camps, and work for little or no fee. CHAWATIATA members are, however, mainly those who work for a fee in

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36 I was asked to translate the official registration of CHAWATIATA for a wider usage.

37 This is a shared opinion of several healers and scientific scholars.
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urban areas. Practitioners who work for free or on the bases of exchange in rural areas still have little dealings with the organization.

In other words, to make CHAWATIATA a successful organisation, the different interests, circumstances as well as working methods of urban and rural practices ought to be properly addressed. Also the fact that very few women are (willing to be) part of the organization needs to be an issue of consideration. That women can play an important role in the organisation is demonstrated by Nuru N'hangachallo, who acts as the local representative of the organization of Dar es Salaam. She has struggled hard to obtain, and subsequently maintain her position within the organisation. Actually, she is the only one in the organisation, who is seriously engaged to represent the interests of the organisation. As an official channel of CHAWATIATA she is constantly in contact with people of the press, radio and television. On account of her contacts with the press and the government officials, not only does her reputation grow, Nuru also receives more clients for consultation and treatment.

Another closely interrelated aspect is that apart from urban centres, most of the regional or district offices continue to register traditional health care providers with cultural affairs. In my last research period (1998/99), very few government representatives in the interior (rural) areas were informed about the recent initiatives of the Ministry of Health or the CHAWATIATA organisation. During my research in 1999, there was only one district cultural officer (rural Iringa) who organized gatherings so as to inform registered healers about the goals of the Ministry of Health Care and CHAWATIATA to organize Traditional Health Care Practitioners (THCP). Even if such gatherings would be organized on a large scale, many healers would not dare to come. According to the district cultural officers, perhaps 50% of all healers in the country are presently registered. This implies that the other 50% works without a permit (kibali) from the district cultural office, which could lead to a fine. In sum, regardless of the good intentions of the organization CHAWATIATA, instability, division and difficulties cross their pathways. It will take many years before it can operate as a national body representing both the interests of the various healers and the various needs of the public.

2.6 Studies about ‘uganga’ in Tanzania

Besides the role of the state, the national healers’ organizations and the modernization process in Tanzania, what have scholarly studies contributed to the discussion of uganga? Apart from Janzen (1992), Feierman (1986) and Mesaki (1998) whom I have mentioned so far, there is Lloyd Swantz, a Lutheran priest from Finland, who conducted research among the Zaramo population of Dar es Salaam between 1965 and 1970. Swantz (1990) wanted to know the problems that the urban Zaramo faced
and to understand the forces they used to preserve traditional values and culture. Instead of writing a book about the subject of witchcraft, as many authors did, Swantz focused on the role of the medicine man among the Zaramo by conducting interviews with them over a time span of five years. He identified various types of persons involved in providing medicines and/or healing in Dar es Salaam: herbalists, Muslim sheiks, Koran teachers, witch-finders, shrine-keepers, street sellers of herbs, traditional circumcisers and midwives. Though some of these persons were not considered in any sense as true healers or waganga, they nonetheless dispensed medicines or performed a religious function. Swantz’ (ibid.) study established that about 700 practitioners provided essential medicinal and healing services to between 8,000 and 10,000 city dwellers a day, leading him to conclude that these practitioners were the most important figures in cultural life of the average urban Zaramo. However, most people did not have explicit concepts about the profession or the dimensions of the practitioners’ activities and roles s/he played in society.

The study by Swantz became a unique contribution to the literature on Tanzanian traditional medicine and healing until this day. In the meantime, more elaborate studies of ethnic healing roles in Swahili populated areas have appeared (1.3), but other parts of Tanzania remain largely devoid of such scholarly attention (1.5). An exception is the study made in the northwest of Tanzania by Marlene Reid which has resulted in an article on the patient/healer interactions among the Sukuma of Tanzania. The author mentions (1982: 112-158) that three types of traditional waganga exist among the Sukuma to expose the cause of a disease: the prophets, the dreamers and the chicken-bone readers. Though each of these waganga could have knowledge over preventive and curative measures, according to Reid (ibid.: 156-157), their authentic role was to restore disturbed relationships. She further mentions that modern health care practitioners expected traditional health perspectives to change once people had become formally educated and converted to the beliefs in modern health concepts. In other words, modern trained staff hoped that the deep-rooted beliefs of traditional ideologies in traditional health care would disappear. The traditional Sukuma waganga reacted to clients’ increased search for curative medicines by adapting their practices. Though in case of magical or spiritual afflictions, treatments were as before aimed at restoring disturbed relationships. From the study it appeared, that a high degree of consensus was found among Sukuma clients, who felt that both traditional and modern practitioners were needed for complete health care. Important in this respect is, that the Sukuma show a resilient attachment to traditional social and religious values. This also goes for the ones who have converted to Islam or Christianity (Varkevisser 1973, Mesaki 1994). Another more ethno-medical study by Harjula (1980) gives insights about the practice of a wellknown herbalist among the Meru people in the Kilimanjaro area of Northern Tanzania. At the time of my study in 1990/91 it was the only in-depth study of a
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healing practice in Tanzania. Because of the ethno-medical nature of this study the author has, however, directed little attention to the cultural and historical background of the healer or to the interaction with his patients.

What studies have been made on southern Tanzanian healing practices and on what aspects have they focused? Some in depth ethnographic information about the efficacy of treating mental disease has come from Edgerton (1971) who studied the practice of a Hehe traditional psycho-pharmacologist in Iringa region in the Southwest of Tanzania. In this study, Edgerton emphasizes the pragmatic nature of the healer’s approach that appeared to have a historical antecedent among the Hehe. The study by Edgerton showed me once again the importance of writing down the healer’s personal history as a means to understand skills and competences. Even if notions of spirits, afflictions or mental disorders concur among healers of the same ethnic group, the approach of treatment can differ considerably. I realized this after conducting my research with a Hehe spirit healer (see chapter 11). Another study of southern Tanzania has come from Gessler, a Swiss biologist, who published a dissertation in 1995 on the anti-malarial potential of medicinal plants used mainly by spirit healers in Morogoro region. Gessler’s research was both ethnobotanical and ethnomedicinal, complemented by interviews and questionnaires. From her findings, Gessler (ibid.: 165) realized that healers administrated different types of plants, according to the patient’s condition. This, she said, would make standardization in the production of plant remedies on a large scale very difficult. The use of plant remedies for specific diseases has to be carefully considered, as several medicinal plants may need to be combined in one prescription. As in Chinese traditional and in Ayurvedic medicine, it is believed that a mixture of ingredients serves to provide the overall activity, and that clinical efficacy cannot be attributed to a single pharmacological compound. Gessler (ibid.: 169) cautions about the complexity of western biomedical approaches in the evaluation of traditional plant remedies.

With respect to Gessler’s remark, I wish to add that the most important and only valid criteria are clinical data from the field, next to accounts of the experiences from various patients. Anthropological studies may provide the foundations for a critical evaluation to decide where, when and how clinical trials should be held. This should not be limited to the usage of plant remedies. Also, other types of remedies in use could be considered for clinical trials, even when they are preventive or placebo remedies. For instance, it is known that many Africans suffer from hypertension, for which large amounts of modern drugs are in use. How local therapeutics, other than plant remedies, may affect hypertension is scarcely studied. Much the same applies for remedies to improve mental health care. Apart from Edgerton (1971, 1977, 1980) only a few studies have been concerned with traditional healers who specialize in
mental health care. Diseases of psychosocial stress, especially depression, neuroses, and psychoses are, however, widespread. Not only are these diseases greatly underestimated among Tanzanian’s urban and rural populations, also the philosophy and structure of biomedical services are poorly equipped to identify and cope with mental and psychosomatic ill health. This is especially the case when spirit afflictions and magical or witchcraft attacks are involved. During my visits to Dar es Salaam I often spoke about this with a psychiatrist of Muhimbili Hospital, Professor Kilonzo, who was much in favor of collaboration between indigenous or traditional and modern health care on a more formal basis. Kilonzo (1994) thought, however, that the waganga could bring improvement to mental patients with ‘minor’ complaints of anxiety and adjustment disorders. Based on my own findings, this appears to me an understatement of what certain indigenous specialists seem to achieve. Even when spirit affliction and/or mental disorders are considered in the light of violations of taboos, witchcraft or sorcery, the complaints need to be dealt with properly. Traditional treatment can achieve this by restoring the harmony in body, mind and even in the social group. I will substantiate this by means of the findings in my study. Here I merely wish to underline that this aspect merits the attention from mental health care workers and researchers (see E. Green 1980).

The pharmacological and ethno-botanical studies of the Institute of Traditional Medicine of the University of Dar es Salaam deal with a very different scope of uganga (see 2.5.2). Most of the studies have been concerned with finding and testing plant remedies for diabetics, cancer and H.I.V. The resources came from waganga on the mainland as well as from coastal areas and comprised herbalists and spirit healers. Mshi u and Chabra (1982) of the Institute of Traditional Medicine have stressed that different types of healers exist in Tanzania who use various cultural approaches. Yet, research has hardly ever been directed to the context and cultural basis from which the waganga practice. Also the role of religion and spiritual guidance has largely been ignored. I am not saying that because traditional medicine and healing is culturally based, patient and healer must necessarily come from the same ethnic group for the treatment to succeed. Nor am I saying that all forms of traditional or indigenous medicine and healing are based on religious and magical beliefs. The efficacy outside of a belief system may be just as valid. What I am saying is that re-

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38 In 1996 I did research for F.U.O.S., a foundation of the University of Amsterdam, to check if a joint project about the knowledge and usage of plant remedies in Ethiopia, Kenya and Tanzania could be submitted for funding by the European Union. I had lengthy discussions with people of the Institute of Traditional Medicine about this proposal and found out that some staff members have personally instigated studies on the three prevalent issues for which they have sought external funds. Local healers provided them with the information of the specific plants.

39 When I reported to the Institute about my research in 1990 nobody had ever remained with a waganga for more than two days.
search in traditional medicine and healing should go well beyond the efficacy of botanical, pharmacological and clinical evaluation, as still many other questions are left unanswered. To some extent, the Public Health Care Department at the Muhimbili University of Dar es Salaam has been concerned with such questions. In 1990 the department carried out studies with herbalists and spirit healers in the Northeastern coast about local illness concepts as they sought to improve preventive measures in the fight against malaria. Concerning the studies that have been made on spirit healing guilds in Tanzania I refer the reader to the next chapter.

2.7 The present constraints for evaluating ‘uganga’

As a consequence of unprecedented social change and the formal constraints to regulate the waganga, they are still seen as a controversial group of health care providers even if many people consult them and an apparent number find a cure or a relief by their interventions. In Tanzania, this controversy has arisen from stereotypical prejudices and biases in favour of modern, scientific medical practice, even when there is also evidence of the efficacy of indigenous healing methods (see Mesaki 1998). As a result of the existing controversy, traditional healers are easily underestimated, albeit by scientist or government representatives. What are the constraints in Tanzania to properly evaluate uganga?

2.7.1 Lack of transparency and coordination

The fact that there is little incentive to study the waganga in Tanzania is as much due to this attitude as it is to a delay in policy making. In his report about the changing role of traditional medicine and healing in Dar es Salaam between the 1970s and the 1990s, Mesaki (1998) sketches in general a pretty dim situation of the present. He deplores the absence of regulation in which the relationship of the waganga to modern medicine is clearly stipulated. The Tanzanian government supports a philosophy to integrate traditional and modern medicine, but does not seem to know how, especially as most modern doctors perceive the waganga with contempt. According to Mesaki (1998:32), effective communication is much needed to bridge the gap between modern and traditional medicine.

Together with Mesaki (ibid.) and Koumare & Coppo (1983), I am of the opinion that more in-depth studies may help to lift suspicion and facilitate the provision of legislation under the authority of the Minister of Public Health. For research to be conducted effectively, it should be directed to a public health goal for which multidisciplinary research is needed. Presently, all researches are registered with the Commission of Sci-

40 These mainly concern unpublished papers, one of which I obtained in 1995 at the Public Health Care Department. See Makemba et al. 1994.
ence and Technology (COSTECH) in Dar es Salaam. Still, there is little transparency and coordination lacks at both the individual and institutional level to document traditional medicine and healing. During my research in the Southern regions, I noticed several times the effects of the absence of a coherent policy. For instance, healers would be penalized for their failures but would rarely be recommended for their success by the district and regional cultural or medical officers. Healers could also complain to me about the role of staff members of the Institute of Traditional Medicine (ITM) who had collected medicinal plants and requested data about their usage. They were promised an official statement based on the analysis of the plant material, but thereafter the healers had no news from the ITM. Many of the healers held the scientists in contempt, afraid that they were misusing their knowledge of plants.

In spite of the current political and operational problems, traditional healers as well as traditional birth attendants are accorded great respect in rural Tanzania. Many people visit them even before turning to conventional medical practices and institutions. If the way indigenous healers operate is still largely invisible, more attention should be given to research on inspired healers who form a large group. Consequently, the negative attitude towards the traditional healers in national health care may change. According to Feierman (1984:28, 1985:108), African traditional medicine does not lack therapeutic efficacy. What it does lack is recognition and understanding, and this in turn leads to a lack of transparency and coordination. The broad spectrum of persons and practices of waganga in rural and urban areas does complicate the evaluation of the potential of indigenous and traditional medicine and healing in general. Proposals of how incorporation, cooperation and integration of traditional healers and their practices can be integrated into the formal or official health sector are therefore postponed (Young 1983, Barmerman et al.1983, Last & Chavunduka 1982, Akarele 1987). On account of the struggle of how to classify indigenous and traditional healers, conflicting terminologies are in use in Africa. Terminologies in use are: herbalist, medicine-(wo)man, witchdoctor, diviner, priest, prophet and ritual specialist to mention just a few of the profuse nomenclature used to describe practitioners whose work is grounded on a traditional approach to illness (Mesaki 1998). In other words, no standard or basic norms exist by which an outsider can clearly separate one indigenous or traditional healer from another.

2.7.2 Definitions for the ‘waganga’

In Kiswahili there are many definitions to refer to the skills and the specializations of the waganga. Whenever the waganga draw on inspirational sources to perform their healing arts, the characteristics of spirits are reflected in the behavior, the magical or power objects as well as the skills performed by the waganga. It is useful to present the most commonly used terms for indigenous healers because identifying one mganga
from another is fraught with difficulties. The list will demonstrate that, in fact, most healers have associations with spirits (see 1.3). Besides the general term for spirit healer \((mganga wa pepo)\), I have identified 23 terms that reflect the specialization of each healer. In a list I present the terms for Bantu healers, the terms for Swahili healers and the terms of a miscellaneous group, making up part of both groups of healers. The terms should not be taken very strictly, however, since many \(waganga wa pepo\) combine various healing skills or healing terms in one practice. This does often indicate that more than one healing spirit guides the healer.

**BANTU HEALERS**

- \(Mganga ya miti shamba\)  
  Herbalist (lit. a healer using plants from the field)
- \(Mganga ya kieneji\)  
  Local or indigenous healer
- \(Mganga wa mkoba\)  
  Healer of the basket (refers to the herbalist)
- \(Mganga wa jadi\)  
  Traditional healer
- \(Mganga wa asili\)  
  Customary healer
- \(Mganga ya uchawi\)  
  Healer counter-acting sorcery or witchcraft or witch-doctor
- \(Mganga mkua\)  
  Senior healer often tutor of a number of novice healers
- \(Mganga wa jadi nchimi\)  
  Traditional healer sent or inspired by God or prophet healer
- \(Mganga wa kuagua\)  
  Diviner gaining insight directly from spirit forces
- \(Mganga wa mila ya desturi\)  
  Healer according habitual customs or a specialist of traditional customs \(\text{(fundī za jādi)}\)
- \(Mganga wa mīmū ya ukū\)  
  Healer inspired by ancestors of the lineage or ancestral lineage healer
- \(Mganga wa mīzīmu ya kale\)  
  Healer inspired by ancient ancestral forces

**SWAHILI HEALERS**

- \(Mganga wa ramli or dua\)  
  Diviner using sacred objects as oracles
- \(Mganga wa jimni\)  
  Healer guided by coastal spirits of Swahili or Arab origin
- \(Mganga wa sheittani\)  
  Healer with special knowledge of devilish spirits that play around with people to fool them
- \(Mganga ya Ruhani\)  
  Healer with coastal or inland divine Arab spirit
- \(Mganga wa dundo\)  
  Healer of the drum
- \(Mganga wa Korani (wa kitabu)\)  
  Healer who works with magic formulas and hymns from the Koran (also healer of the book)

**MISCELLANEOUS**

- \(Mganga wa imani\)  
  Healer who holds faith in (divine) spirit forces
- \(Mganga wa kioo\)  
  Healer who owns a mirror to see past or present events
- \(Mganga wa bokolo\)  
  Healer who bought the skills from another healer
- \(Mganga wa kiboko\)  
  Healer who tricks people and exploits them

The problem to define the \(waganga\) in national health care has much to do with the dichotomous meaning of 'health care' and 'medical care'. In health care, emphasis is
on providing means to improve general wellbeing, whereas in medical care, emphasis is on bringing relief or cure of biological or neurological symptoms. Traditional healers may provide both. Some authors have also referred to a traditional medical ‘system’ (Good 1979, 1987; Feierman 1979, 1985). To my mind one should be careful to speak of a ‘system’ because indigenous or traditional healers are very heterogeneous and above all, too little is known about these healers. This does not mean, that Africa has never had a unique system of traditional medicine, but only a vast variety of different beliefs and practices (cf. Velimirovic 1984: 64). In a WHO-reader on traditional medicine and health care coverage, Koumara and Coppo (1983: 25-29) mention that indigenous healers who practice traditional medicine, are persons recognized by the community in which they live, as competent to engage in medical and non-medical activities. The all-embracing nature of African traditional medicine is seen to be the reason for the wide variety of practices encountered. To be able to better categorize traditional healing practices, Koumara (ibid.: 27) proposes to distinguish three types of practices:

- Practitioners using medicinal substances.
- Practitioners concerned with ‘intangible forces’ and rites.
- Practitioners that combine the two previous groups.

I assume that the third category represents the biggest group of traditional health care providers. This is precisely why it is practically impossible to narrow them down into clear groups or categories. Even the healers do not always make strict differentiations. A specialist in herbal remedies, for instance, may also use divination or receive guidance from a helpful spirit. Partly through this spiritual guidance, a healer learns which specific medicine to use for a particular therapy and person, where to find the ingredients, and how to prepare and administer the medicine. Spiritual guidance may also influence the choice of rituals, offerings or musical and/or group sessions. In some cases, indigenous healers have a healing heritage from ancestral kin, whereas others learn the skills from a variety of spirits. Some healers are highly skilled in the treatment of physical complaints such as infertility, impotence and sexual problems, or bone-fractures and internal infections, whereas others have a good reputation in the treatment of mental illness.

The Ministries of Health and National Medical Associations may define who is or is not a legitimate physician, but they are at a loss with regard to traditional healers. At the same time, traditional healers themselves lack authority to exclude practitioners who are incompetent, greedy or not trustworthy. To some extent, healers may contribute to feelings of distrust because they do not wish to reveal their knowledge, but often this has to do with fear that their knowledge will be abused. Some healers may also suggest treatment for complaints they are not able to remedy, just to obtain
money. Devoted healers may work for free or ask only to be compensated for expenses, but others may ask relatively high compensations. The specific abilities and competences of the healers may only be known to relatives of the healers and to their (ex) patients. For others it may be hard to discern their qualities and competences. Patients, or those whom take decisions for them, may thus have a hard time deciding where to find the most appropriate healer. Good (1987) who studied patterns of traditional medicine in Kenya, rightly points out that the search for therapy may be conducted over a period of weeks, months, and even years. He further mentions (ibid.: 155) that specific cases imply an endless search for a cure. In cases of chronic and terminal illness, the sufferers, or their therapy management groups, may become so desperate that they will try anything. Such people, as in western society, are prone to fall into the hands of money gougers or fake healers.

2.7.3 Negative attitude and publicity

It has been shown that the changed situation of the urban areas has influenced both the organization and the status of ugangga on a national level (see 2.5). One of the consequences is that rural spirit practitioners, who work under quite different local and cultural circumstances, are insufficiently addressed in the organization of ugangga. The reason is simply that little is known about them and their work. From my own study, I noticed that the district and regional cultural officers hardly knew those healers who worked with an official permit (kibali) from the district cultural office. In my search for renowned spirit healers, I sometimes received help from the district cultural officers, but they could be at a loss as to where to start. Their goodwill to accompany me, or introduce me to healers, did not always render success. Some healers would be reluctant to answer the questions of cultural officers, afraid to be fined for illegal actions. For instance, as mentioned in their permit, it is illegal to use divination as a means to diagnose or establish treatment. Practically everybody knows, however, that divination and dreams are the main source of inspiration and information for the majority of traditional spirit healers. Without this capacity there is no spirit (pepo) healer. Other than the lack of legal foundations, what else is behind this lack of trust between these traditional healers and government officials?

Negative publicity concerning fraudulence, exploitation, incompetence, and even fiendish and diabolical acts of healers tends to outnumber the positive publicity of the respectable and popular waganga. Subsequently a lot of mistrust has evolved around the person and the role of the waganga in Dar es Salaam. The negative publicity of

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41 It was compulsory for me to report at regional and district cultural offices and inform about my presence. A letter of introduction from the Commission of Science and Technology stated that I was permitted to conduct research. The officers were requested to facilitate me as much as possible.
the last twenty years has also come from the numerous witch-killings often directed at older people, especially women. Ever since 1970, witch-related incidents have been reported to the police in Tanzania, which resulted in the death of 3.693 people, 1.407 were males and 2.286 were females (see 1.3). According to Mesaki (2002), these killings represent a crisis embedded in poor educational, health, and development services in certain rural areas; yet a crisis-management operation has not been set in motion by the government. The highest incidents of killings take place in the northwestern regions, specifically among the Sukuma in Mwanza, Tabora, Shinyanga and Singida. Major incentives to the killings appear to be quarrels and conflicts over land, properties, and, above all inheritance. The fact that local authorities take bribes to keep silent about the murderers, does not simplify the situation. Community leaders are calling on the government to take strong measures to prevent the killings and, in many cases they point to the waganga as the ones who instigate the killings. I will return to this aspect in 3.3.

The diviners (bafumu sing. nfumu) of the Sukuma, seem to be highly involved with offering illegitimate services. Mesaki (ibid.) states that, though divination used to be an honorable profession of a relatively small number of learned practitioners, many quacks and charlatans focused on money have now invaded the sacred profession. Due to the abolition of traditional leadership in 1963, the control by local chiefs to take measures in case of incompetent or dishonest healing practices in a community, has disappeared (see 2.4). This changed with the installment of modern bureaucracy, which created a vacuum with regard as to how to deal with witchcraft fears and attacks. As a consequence, fake healers could obtain official permits (vibali singl. kibali) from the cultural department and operate with the tacit acknowledgement of the government (see 2.5). In the course of presenting this study I hope to provide some answers on how to distinguish real traditional (spirit) healers from fake ones.

2.8 Prospects for development

Recently, some new developments are taking place. For instance, the OAU (Organization of African Unity) has attempted to bring some unity in policies on traditional health care. This followed from a resolution of a meeting in Togo of African heads of States in 2000, in which all African countries agreed that this would be the decade of traditional medicine in Africa (2002-2010).42 The WHO Regional Committee for Africa has adopted the resolution in 2000 in a declaration called Promoting the Role of Traditional Medicine in Health Systems; A Strategy for the African Region 2001-

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42 The information has come to me from colleagues in Tanzania and from organizers of the Conference on Traditional Medicine and community health care held in Nairobi in 2000 in which I participated. The issue was further discussed in a conference on traditional medicine and benefit sharing in Morocco in May 2002.
The Role and History of Uganda

2010. The declaration recognizes the importance and potential of Traditional Medicine for the achievement of “Health for All” in the African Region, and recommends accelerated development of local production of traditional medicines. The declaration further urges Member States to translate the strategy into realistic Traditional Medicine policies, backed up with appropriate legislation and plans for specific interventions at national and local levels, and to collaborate actively with all partners in its implementation and evaluation. Concrete results are now beginning to appear, including legal frameworks for traditional medicine in 16 African countries. By January 2002, a plan has been drawn up in Arusha, Tanzania, on how to operationalize the declaration in Africa. It seems that the World Bank, the IDRC and UNIDO are among the potential funders. In October 2002, the Parliament of the United Republic of Tanzania introduced a bill for an act to make provisions for the promotion, control, and regulation of traditional and alternative medicine practice. The enactment will lead to the establishment of the Traditional and Alternative Health Practice Council and provide for related matters to reach the goals of the OAU declaration.

To this date I have no information of what the declaration has outlined with regard to Tanzania. I do know that on a local level, a remarkable development is going on in Tanga region. The region has over 670 registered traditional healers. Out of an initiative of physicians and local healers, an experiment evolved in the nineties to jointly fight against HIV/AIDS. A promising program was implemented by the name of Tanga Aids Working Group (TAWG). TAWG was officially registered with the Ministry of Home Affairs in 1994 as an innovative non-governmental organization (NGO). TAWG not only linked together traditional healers, physicians, health workers and people living with AIDS, also botanists and social scientists were actively involved. Its primary goal was, and still is, to bridge the gap between traditional and western biomedicine by treating AIDS patients with traditional plant medicines at the government hospital of Tanga. The treatment generally lengthens and improves the quality of life of a patient. Not only is appetite increased, but people also gain weight as diarrhoea stops and fever is reduced. Furthermore, the treatment resolves skin rashes and infections, and remedies herpes zoster and ulcers. The earlier treatment is started, the better the results. Since TAWG began in 1990 around 2000 patients have been treated. Currently TAWG treats about 400 patients in Tanga, Pangani, and Muhheza district free of charge. TAWG works closely with the government, runs seminars for traditional healers and has an effective education and HIV/AIDS prevention program. Support has been obtained by OXFAM, The World Bank and USAID.

44 In 1996 I visited TAWG and continue to have contact with its founder David Scheinmann. TAWG's activities have been reported on-line by BBC NEWS (September 2002) and by the on-line magazine Science in Africa (November 2002).
2.9 Conclusive remarks

Traditional healers interpret and treat illness within the broader context of life forces in which emotional or traumatic experiences, social relations, but also magic and witchcraft may play an inextricable part. In Tanzania these healers continue to have a strong appeal to users. Legal support of traditional medicine and healing by the government of Tanzania is, however, still absent and an atmosphere reigns that lacks trust by the various parties concerned. Many changes have taken place in the past two centuries, notably caused by tribal- and colonial wars, Christianity and modernity. Today syncretism has become part and parcel of healing or uganga, be it in terms of skills, spirits, working habits- or ethics. This diversity goes hand in hand with an increase in the number of practitioners. The many changes that have occurred in uganga tend to make the activities of the waganga more restricted to problems of individuals instead of also involving the family groups. Many waganga still use divination or dreaming to find the cause of illness or misfortune and advise about a cure or solution; which they themselves may provide be it with the help of herbal treatments, or by conducting rituals to influence the spirit world. Depending on the skills, interventions, power and authority, the waganga will be accorded prestige by clients, family and community members.

The waganga depend on creative and metaphysical skills and are much concerned with the psychological or psychosocial aspects in illness. In this respect, the definition of ‘health’ by the WHO (1998) - that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity - should be given its proper consideration. As more diseases occur as a result of increasing complexities of life, African governments should be well aware of the role that traditional health care plays for the wellbeing of people. Nowadays, African governments are striving to define what licensing, legislation, and quality of control means in the face of medical pluralism, but only few countries have as yet resolved the issues at stake. The best way to do this is not merely to regulate traditional health care, but also to stimulate it and explore its merits. The TAWG initiative serves as a good example of how positive results can be achieved in the fight against AIDS by combining forces from local expertise and resources of indigenous knowledge with modern health care, providing effective low cost treatment. Other diseases and recurrent mental problems too could well be met in this fashion.

Provided that the lessons learned from the past ten to twenty years are given proper attention, there are sparkles of hope for positive developments. Janzen (1985: 68) is confident about the future when he says: “...as research continues, more and more segments of African medicine will be brought under the banner of scientific legislation, and will be accepted as an official part of the national trust.” On the one hand, I hope Janzen is right but, on the other hand, I fear the implications of industrialization and
commercialisation of traditional medicines. With an increased interest in the production of natural ingredients, the emphasis of research-projects and studies is on the biochemical components of medicinal plants. Gradually, this development may place the role and skill of the individual healer in the background, as is happening with Ayurvedic practitioners in urban centres of India (see chapter 1).\textsuperscript{45} The ongoing development process, geared towards increasing profits and economic improvements, also tends to undermine traditional knowledge and skills incorporating holistic approaches towards human life and its resources. These are in particular essential in religious forms of healing.

\textsuperscript{45} Oral information obtained from the anthropologist Maarten Bode (University of Amsterdam). He has done elaborate research into the role of industrialization in Ayurvedic medicines in India. Publication of his dissertation is expected in 2004.
The healer Nuru N’hangachallo during a consultation in her clinic in Dar es Salaam

Nuru N’hangachallo in front of an ancestral Cwezi hut in her home region Tabora