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**Rethinking Indigenous Medicine: Illness (mis)representation and Political Economy of Health in
Mozambique's public health field**

Narciso António Mahumana

Thesis Submitted for the Degree of Doctor of Philosophy in Social Anthropology

University of Sussex
School of Global Studies

September, 2013

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature:

SUMMARY

This dissertation was motivated by the misrepresentation of, and apparent lack of knowledge about, indigenous medicine in Mozambique. This consequently raised the need to reveal the epistemologies of health, illness and healing; rewrite the historiography; and develop the knowledge of and about this medicine. The dissertation analyses illness representation and the political economy of health. The thesis defended is that indigenous medicine is a form of medical knowledge and practice that represents its illness, therapy and efficacy according to specific epistemological foundations, rooted in the local society and culture yet it has been misrepresented by local discourses, agencies and practices that battle to control health resources, knowledge and power in Mozambique. Within this, biomedical health paradigms, bodies, and representations have been imposed onto an imagined Official National Health Service (ONHS) whilst people, on the other hand, represent, legitimise, and seek therapy simultaneously in different epistemologies and practices of medicine within the therapeutic landscape creating a Contextual National Health Service (CNHS). This political economy of health is contingent on historical, socio-economical, political and geopolitical productions and constructions of health and efficacy within Mozambique's public health field. Research and health development needs to rewrite the historiography of indigenous medicine based on ethnographically sensitive material and linguistic competence. The construction and justification of this argument is made in seven chapters.

The study was carried out in Maputo City and Manhiça district and relied on participant observation. It also uses a mixture of other qualitative methods which encompassed formal and informal interviews, documenting of life histories, desk review, and participatory learning for action (PLA).

DEDICATION

I dedicate this dissertation to my late father, who, in spite of the poor conditions in which he raised us, constantly reminded my brothers and myself of the importance of study to our lives and to our development. Thank you father, I never gave up, and I will keep transmitting your wisdom to your grandsons.

ACKNOWLEDGEMENTS

Many people gave me psychological, social, academic and economic support to undertake this PhD. My hard work would have never succeeded without their direct and indirect support. Thank you very much to all of you. My especial gratitude goes to the following people and institutions:

Ford Foundation Fellowship Program for awarding me the scholarship, and to the African American Institute (AAI) and its staff in Maputo who administrated the program and gave me their undivided attention. At AAI I can't ignore the competence and support of Dr. Célia Diniz, who initiated the program, and Dr. Mouzinho Mário, the director for the last year of my PhD.

PROMETRA for its logistic support, and for granting access to indigenous medicine networks and practice.

My wife Marta Belarmina, my son Narciso Mutema, and my daughters Thandi, and Kufasi for the care, and patience they had in tolerating my absence and the difficulties in the last four years. It would have been difficult to complete this doctorate without your support.

Professor James Fairhead, my main supervisor, for his continuous support, care, patience and for pushing my thoughts during our inspiring discussions. Professor Andrea Cornwall, my second supervisor, for her supervision and support.

Miguel Marrengula, a Ford Fellow colleague and close friend, for his undivided social, economic and psychological support. You are the sort of friends people should have. My friends Sonia Nhantumbo, for supporting my field work, Benjamim Macuacua, for his help with the education of my children during my absence, Bweti Maggie for her care and emotional support.

I would also like to thank my friends Karen Boswall and Sidónio Givandas who supported me during my studies, especially in my black out moments. Staying with you at Whitstable was inspiring and helped me a lot to continue battling the dissertation.

Mariana Dzimba, my *b'ava*, for the apprenticeship and training to *nyamusoro*. Thank you very much for your care and continuously sharing the millenary knowledge and medical practice of indigenous medicine.

The *tinyanga* from Maputo and Manhica without whom it would have been impossible to reveal the knowledge and medical practices of indigenous medicine. Particular thanks go to the participation groups, key informants and those interviewed during my fieldwork.

Those who supported me with data and sources of information. Any intention to name you would risk filling ten pages. Thank you all.

Suzana Rita, and Colégio Nyamunda, for your support with the education of my children during my studies. It would have been very difficult without your especial care.

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LIST OF ABBREVIATIONS

CIDE – Centre for Research and Development of Ethnobotany/Centro de Investigação e Desenvolvimento da Etnobotânica

CNCS – National Aids Council/Conselho Nacional de Combate ao SIDA

CNHS – Contextual National Health System

DPMMT - Department of Medicinal Plants and Traditional Medicine/Departamento de Plantas Medicinais e Medicina Tradicional

ECTIM – Mozambique's Science, Technology and Innovation Strategy/Estratégia da Ciência e Tecnologia e Inovação de Moçambique

IMT – Institute of Traditional Medicine/Instituto de Medicina Tradicional

INS – National Institute of Health/Instituto Nacional de Saúde

LMDH - Mozambican League of Human Rights/*Liga Moçambicana de Direitos Humanos*

MISAU - Ministry of Health/Ministério da Saúde

MST – Ministry of Science and Technology/Ministério da Ciência e Tecnologia

MSA - Ministry of State Administration/Ministério da Administração Estatal

NGO – Non Governmental Organization

PCT – Policy of Science and Technology/Política da Ciência e Tecnologia

PTM – Policy of Traditional Medicine/Política da Medicina Tradicional

ONHS – Official National Health System

PROMETRA – Promotion of Indigenous Medicine/Promoção da Medicina Tradicional

WHO – World Health Organization

CHAPTER I - INTRODUCTION

1.0. Introduction

1.1. Context and Justification of the Study

Rethinking Indigenous Medicine: Illness (mis)representation and the Political Economy of Health in Mozambique's public health field attempts to develop knowledge of and about indigenous medicine¹ in Mozambique. It analyses the meanings and characteristics attached to indigenous medicine by different stakeholders, particularly of illness representation and models of efficacy.

I have been interested in indigenous medicine and public health in Mozambique since my early childhood. My grandfather and grandmother were both *tinyanga*² with whom I had strong social ties. The former was *nyangarume*, and the latter *nyamusoro*³. My father was an ambulance and program support driver at the ministry of health, Maputo provincial directorate of health. When I was young I made journeys with him to assist health campaigns and visit district hospitals. I would always stay at the nursery or house of the physician in chief. His wanted to show me health campaigns and hospitals, "(...) doctors working...so that you can became a doctor one day (...)". In this context I grew up witnessing therapeutic endeavours, and patients practicing "syncretism"

¹ Due to nominalisation constraints, I use this very systemic term to refer to the local medical traditions and practices, based on endogenous epistemologies practiced earlier than biomedicine, typically referred to as traditional medicine in contrast to biomedicine. Following Nichter & Lock (2002); Leslie (1980a; 1980b) my work assumes that all medical traditions encompass simultaneously elements of modernity and tradition, and that they are adjusted to the different contexts in which they are used in order to adapt to local lifestyles. The dualism of traditional and modern medicine is fallacious since all bodies of medical knowledge change over time due to political and social factors as well as technological innovations and the diffusion of knowledge.

² Term used to refer to indigenous medicine health providers in Southern Mozambique, the singular form is *nyanga*.

³ *Nyangarume* and *nyamusoro* are types of *tinyanga*. See Chapter V for further description.

between indigenous medicine and biomedicine⁴. Concomitantly, I realised that the meanings attached to indigenous medicine in different social and historical contexts were contradictory.

I have always been perplexed by the fact that indigenous medicine withstood the hostility of western modernity, and that people did not give it up despite its persecution under the colonial regime, prohibition by the post-colonial government, and, nowadays, denigration by Pentecostal churches. I have been bewildered too by the fact that indigenous medicine has been outlawed and its use not promoted at the Official National Health System (ONHS) whilst it is used by the majority of the population.

I began to give my undivided attention to public health vis-à-vis indigenous medicine nineteen years ago when I underwent an indigenous medicine course and graduated as *nyamusoro* after three years of training and apprenticeship. I now attend patients of all ages and status and I am involved in a large network of *tinyanga*. This exposed me to health debates in Mozambique and raised my interest in patient's encounters with health services. I became sensitive not only to issues of the health rights of patients but also the rights of different 'healers' to practice, and the limited power of negotiation and positioning between them and the State.

In their daily lives, many Mozambicans establish multiple links with the available array of 'healers', and encounter contrasting, and sometimes, conflicting healthcare paradigms and discourses⁵. Yet contradictions remain between local representations of illness and Mozambican health policy in terms of the degree to which indigenous medicine should be treated, *inter alia*, both as a form of knowledge and as a health service. There is evidence that the different stakeholders, such as policy makers, researchers, journalists, and NGO's, harbour

⁴ Medical tradition and practice originated in the 'west', also known as orthodox medicine, represented with the principles of systemic biology, currently globally used in hospitals.

⁵ Discourse is here seen as words plus things, and their rules of production and delimitation of the field of knowledge (Foucault 1972; 1989 [1975]).

misunderstandings about the ways indigenous medicine works; how it represents sickness and its models of efficacy. There is therefore a need for more research into this medicine, its characteristics and practices, offering an interpretation that explicitly takes the historical, biological, social and political meanings locked inside health/illness into account. I intend to contribute to this field by revealing local epistemologies of health, illness and healing (medicine), and rewriting the historiography of indigenous medicine. I will pursue this main objective by exploring the social and historical foundations of the representation of health/illness in Mozambique; tracing the continuities and discontinuities of local stakeholders in relation to the representation of indigenous medicine; revealing and building knowledge on local therapeutic landscapes; examining the therapeutic delivery and choice; and analysing the political economy of health in Mozambique.

Chapter IV explores the social and historical foundations of the representation of health/illness and efficacy in Mozambique. The argument of the chapter is that the debates about indigenous medicine in Mozambique are questionable because they have endured, *inter alia*, socio-historical, theoretical, epistemological, and methodological constraints. I will show the different ways in which indigenous health has been (mis)represented by local stakeholders during the colonial period, after the independence, and in the neoliberal era.

In chapter V, I use the philosophical and methodological paradigms of phenomenology and histories of social sciences to examine how health, sickness and healing are experienced by those who use indigenous medicine.

In chapter VI, I respond to the question about health provision and 'choice' looking at the features of the therapeutic landscape and the factors that incite patients to decide on using a specific health service or therapy. In the discussion I argue for the revision of the notion of therapeutic choice.

In chapter VII, in order to respond to issues of power relations in the representation of illness and efficacy by different stakeholders in modern Mozambique, and how social conditions and power relations produce, reproduce, and legitimise health practices, based on my findings of previous chapters, I present my reflections on the political economy of health.

In the following section I summarise some basic information about Mozambique and the context of health delivery there.

1.2. Background on Mozambique

Mozambique is situated in Southern Africa (Southeast Coast) and shares borders with Tanzania (north), Swaziland and South Africa (south), Zimbabwe, Zambia and Malawi (west) and Indian Ocean (east) – see map 1 below.

Map 1. Location of Mozambique



The table below provides information about Mozambique's population, territory, climate and Official language. This data was extracted from the 2007 general census.

Table 1. General information about Mozambique

Population		Area	Climate	Linguistic situation
Total	23.049.621	799.380 Km ² (496.817.9 Mile ²)	Inter-tropical	Linguistic diversity: Portuguese (Official, 24% of speakers). Bantu Languages (around 20, regional, 76% users) ⁶
Female	11.941.493			
Male	11.108.128			

The three last national censuses did not inquire into medical 'systems' and users. Data from the Traditional Medicine Policy (PMT)⁷ show that more than 60% of people have access only to indigenous medicine for their health needs and 40 % use both. According to these percentages the public health context is one of medical pluralism⁸ in which both indigenous medicine and biomedicine deliver health services, and patients establish multiple relationships with the available 'healers'. Notwithstanding this medical 'syncretism', official public health delivery and local debates are rooted in biomedical discourse, gaze and planning.

⁶ Firmino 2005

⁷ See Governo de Moçambique, BR nº 15, I Série de 14 de Abril de 2004

⁸ Pool & Geissler (2005) assert that medical pluralism is the 'syncretic' utilisation of different medical traditions within one society or one medical 'system'. These concepts are discussed in chapter II (the literature review chapter).

According to WHO 2003⁹, the ratio of *nyanga* to the population in southern Africa compared to the ratio of doctors is as follows:

Table 2. Ratio *Tinyanga* per population compared to doctors

Ratio <i>Tinyanga</i> per population, and biomedical doctors in some southern African countries		
Country	Ratio <i>Tinyanga</i> per population	Ratio doctors per population
Mozambique	1:200	1:50.000
Zimbabwe	1:600	1:6.250
Swaziland	1:100	1:10.000
Tanzania	1:400	1:33.000

The table reveals that medical 'pluralism' is a common phenomenon throughout Southern Africa. The figures also illustrate that Mozambique has a higher proportion of *tinyanga* than of doctors, around 115.000 *tinyanga* and 500 doctors for the approximately 23.000.000 people. The statistics do not differentiate categories of *tinyanga* and conceal the fact that biomedical services are also provided by nurses and technicians of medicine. Therapeutic choice and delivery cannot be reduced into numbers because it is a praxis and experience that can best be captured through observation.

1.3. Problem statement and motivation

This dissertation examines the historiography of indigenous medicine in Mozambique, looking at the representation of illness and efficacy, and the related political economy. An analysis of the way its representation has been constructed raises a number of questions in relation to its

⁹ OMS. 2003. *Observatório da Saúde*. Volume 4, nº 1. Brazzaville: Escritório Regional de África.

practice and ontology. In the next paragraphs I outline the problems that attracted me to this research.

Firstly, in Mozambique, public health planners and biomedical health professionals perceive people's representations of health rooted in indigenous medicine as forms of ignorance and resistance to biomedical knowledge and health delivery. They suggest that these practices are negative cultural practices; beliefs resulting from ignorance and erroneous views about health and sickness (see Governo de Moçambique 2008; 2010). I have been engaging with these sorts of narratives all my life and have encountered similar discourses during my research for this dissertation. They are generalised in newspapers and magazines (see *MozCeleb* p 93; *Notícias* 20.03.2008 p3; 02.08.2008 p7, *O País* 19.03.2009 p22; *Savana* 29.07.2011 p9; *Verdade* 02.05.2012 p5), and heard them in a number of seminars conducted by institutions such as the Institute of Traditional Medicine (IMT¹⁰), National AIDS Council (CNCS¹¹), and other NGO's. It is generally said that the people's representations of their health, their bodies, and their relationship with the living and their ancestors are beliefs about the invisible world. Does this mean that they cannot be assessed through scientific methods? The Mozambican sociologists Carlos Serra uses the terminology 'visible' vs. 'invisible forces' and 'belief in these forces' quite often in his sociological reflections (See *Fungulamaso* 1-14, *Savana* newspaper from June, August and September 2010 issues). During the celebrated *Quisse Mavota* in which students from the Quisse Mavota School experienced spirit possession, Elisio Macamo, another Mozambican sociologist, termed all explanations of the phenomenon based on indigenous medicine as irrational, expressions of arrogance, bizarre beliefs, and obscurantism. He claimed that the 'belief' in spirit possession and 'existence' of spirits or producing 'fantastic discourses' about them 'as anthropologists do' (!) is irrational and unscientific (cf. *Notícias* 26/05/2010; *Verdade* 27/05/2010).

¹⁰ Instituto de Medicina Tradicional

¹¹ Conselho Nacional de Combate ao SIDA

This is to say, its practice and social fabric cannot be explained in any methodically and epistemologically sensible way. In their biomedical attempt to explain the phenomenon, psychologists and physicians from the ministry of health, without any training in management of spirit possession and spirit involvement, used idioms such as ‘anaemia’, ‘emotional falls’, and ‘collective hysteria’ motivated by ‘superstition’ and ‘traditional beliefs’. Yet, in order to find their explanations, they did not mediate with the people affected by the problem who demanded for and used indigenous medicine idioms and medical practices to solve the problem.

Considering that all claims of knowledge are products of particular socio-cultural assumptions which configure ways of seeing, saying and representing the truth (Foucault 1980), it is reasonable for this dissertation to question: How did different cultural agencies and social structures give rise to these ideologies? What role have different political processes played in the representation of illness and efficacy? How was health/illness and models of efficacy of indigenous medicine accessed and represented throughout history? What are the continuities and discontinuities of this representation?

The second problematic issue that drew me to this research is embodied in the statement below by Mozambican university lecturer of philosophy and philosophical anthropology Silvério Ronguane, who asserts:

“Here we have another weakness of indigenous medicine, there is no Order of Doctors (*Ordem dos Medicos*), and therefore there are no parameters (to become an indigenous medicine practitioner). One becomes a lawyer through a university assessment. A faculty of medicine has concrete evaluation tools, and it is easy to see whether you are a doctor or not. (...). Any medical systems needs a context, it cannot operate without the idea of objective science. (...). If truth be told, in terms of Ideological discourse biomedicine has won (the public health space in Mozambique)” Silvério Ronguane, extract from an interview in *PROLER Magazine*, 2008, pp. 7-8) – free translation.

Ronguane claims that indigenous medicine has neither internal parameters for graduation nor a sound foundation of knowledge when compared to biomedicine. According to this Mozambican scholar, indigenous medicine has no training 'schools' for the *tinyanga*, no local systems of specialisation, nor models of professional legitimisation. Is this well informed? Is Ronguane's view, that the current inequalities in health space should be ignored since biomedicine has won ideologically, valid?

Closely associated to Ronguane's belief is the problematic issue of the definition of the typology of illness and *tinyanga* which raises generalizations and classificatory stereotypes. Within Mozambique the *tinyanga* are cast as a homogenous community with a homogenous repertoire of practices. In local health plans, the media and in the everyday discourses I have witnessed, *tinyanga* are termed practitioners of indigenous medicine¹² or *curandeiros*¹³; a homogenous cohort of practitioners. This undermines or ignores the specialisation and hierarchy of indigenous medicine. Local literature is poor on distinguishing between the categorically different types of healing practices which are not biomedical (see Green 1995; Green 1999; Green et al. 1995; Monteiro 2011; Palha de Sousa 2005), and when these distinctions are drawn, they use ethnographically problematic and reductionist concepts which are not grounded in local languages and experience (see Kotanyi 2006; Granjo 2005; 2006). For example, Granjo uses the term *tinholo* (hand tools) for *tinhlolo* (indigenous medicine diagnostic tools), and by using the term 'exorcism', he reduces the indigenous medicine practise of spirit medium to that of the Christian concept of exorcism. He also uses the name *nulu* for the medicine used in the training of *tinyanga* (*govo*) whilst the plant *nulu* is just one among the 9 plants used in this medicine. Many questions arise from this: Is indigenous medicine a homogenous block of practices, as these perceptions

¹² *Praticantes de Medicina Tradicional* – PMT's

¹³ *Curandeiro* is a colonial classificatory and pejoratively perceived term analogous to healer with no counterpart in local meaning

suggest, which operate in ways that are opposed to/by bio-medicine? Does indigenous medicine have typology of illness? What are the internal varieties and rivalries between forms of indigenous medicine? How do some *tinyanga* and some people from the community cast other *tinyanga* as disreputable (as 'charlatans' for example)? Above all it would be interesting to start by asking what are the local therapeutic landscapes of indigenous medicine?

The fourth problematic issue derives from the ambiguity of some policy and decision makers at the Ministry of Health. On one hand, in their public interventions they claim to lack knowledge about indigenous medicine, and on the other, they have been seen utilising indigenous therapies or have signs of having used them. For example, when João Fumane, former director of the National Institute of Health (INS¹⁴), was asked by a member of the audience at the III Seminar of Health¹⁵ in Mozambique, why the State is not developing indigenous medicine and integrating it in the ONHS, he replied that they knew nothing about indigenous health practices, hence they feared, and were unable to develop this unknown medical practice. Yet, informally, it is clear that Fumane and fellow health planners make use of indigenous epistemologies of health, and have narratives about their encounters with the *tinyanga*. My observations reveal that about three fifths of those within the Ministry of Health and other State departments have *tinhlanga*¹⁶ from indigenous medicine. How can this contradiction be understood and placed in the wider social attitude and relationship with indigenous medicine?

Fifthly, there is the problem of vulnerability of the *tinyanga*, their families, and patients in the therapeutic process. The Ministry of Health supports their biomedical counterparts with surgical equipment while *tinyanga* are exposed to a number of contemporary infectious diseases while being overwhelmed by criticisms about the way they deliver health services. For example, local

¹⁴ Instituto Nacional de Saúde

¹⁵ III *Jornadas de Saúde*.

¹⁶ Scar from a sort of indigenous medicine 'vaccination'.

discourses accuse them of re-using blades to *tlhavela*¹⁷ their patients; of not telling them to take (antiretroviral) tablets from biomedical services, and of not ensuring the safety of their medicines. It is said explicitly that “(...) they jeopardize health” (see Eliana Ferreira in *MozCeleb* issue I: 93; Nazira on the 31st August 2010 TVM’s *Telejornal*; West’s *Kupilikula* 2005). This approach condemns ‘bad practices’ but misses an analysis of their underlying structures and motivations. This ends up privileging some forms of medicine and downgrading others.

In cities like Maputo the liberal economy and the commercialisation of indigenous medicinal services has encouraged profiteering to the cost of patients. Sometimes it is not clear where the responsibilities of the *tinyanga* end and the rights of the patients begin in the therapeutic encounter. Ethical practice is not mandated by any regulatory procedure, but is instead conditioned by the will of the therapist. There are narratives of patients who claimed they were badly treated by the *tinyanga*.¹⁸ The biomedical-oriented thinking usually generalises these attitudes to all practitioners when discoursing indigenous medicine, and as such cast the whole system as disreputable, and *tinyanga* as ‘charlatans’, their practices as *curandeirismo*. This problematic is interesting for medical anthropology if discussed in terms of structural violence (Falmer 1997) and political economy of health (Adams 2002; Baer et al. 1997; Nichter & Lock 2002). These perspectives would ask how local institutions, health planning, social mobility and power constrain certain social health practices, and how health delivery is shaped by the political and economic relations of power.

Overall, all the problems presented above infer that health, illness, healing and the control of the body and self are supposedly an exclusively biomedical activity. This marginalises indigenous health practices and, consequently discourages proper academic inquiry and other forms of

¹⁷ ‘To vaccinate’

¹⁸ In both PROMETRA, where I work, and during my health delivery, I received women who were apparently badly diagnosed and given harmful treatments.

development. Does this knowledge about health, illness and medicine properly construe local medical *lifeworlds*¹⁹? The central issue is what we mean by, and how we inquire into, illness and efficacy? What is it to be sick and to be healed for those who use indigenous medicine? What is a suitable approach to the analysis of indigenous medicine?

These analytical questions bring together my academic and social concerns as both an anthropologist and *nyanga*. They lead me to developing knowledge of and about indigenous medicine that does not deny its epistemologies of health, particularly those of illness representation and models of efficacy. In order to explore them: Firstly I explore both the continuities and discontinuities of the State in relation to the representation of indigenous medicine, and the different ways in which illness has been represented in public health, political and academic discourses. Secondly, I focus on the therapeutic landscapes of indigenous medicine, addressing, *inter alia*, its professional practice, its community of practitioners, its illness representation and its models of efficacy. Thirdly, I will examine therapeutic delivery and choice. Lastly, I will analyse the political economy of illness and its efficacy in the plural public health field, in relation both to illness representation and to identities of indigenous medicine.

This dissertation examines the debates on the medical landscapes in Mozambique which are, as yet, inadequate, since they do not examine the full repertoire of medical practices, and the representation of health/illness and models of efficacy of indigenous medicine²⁰. The debates are incomplete in the way they address both the different ways local institutions and agencies treat existing medical traditions, and the local forms of compliance and 'resistance' to this attitude. Socio-historical discourses and paradigms claiming to represent the truth about health and

¹⁹ Concept suggested by Michael Jackson: "(...) When we make cross-cultural comparisons between various "systems of thought", we would do well to construe these not as worldviews (*Weltanschauungen*) but as lifeworlds (*Lebenswelten*)." (1996:6)

²⁰ Some rare exceptions are ethnographically sensitive on specific aspects of indigenous medicine such as spiritual agency (see Honwana 2002; Bagnol 2008).

sickness do not explain why, despite the denigration of indigenous medicine by the political and school system, people chose it for therapy. The debates also fail to look at health practices as economic resources. I will therefore look into relations of power among different stakeholders that make up the public health field from the perspective of a political economy of health. Drawing from ethnographic research in Maputo city and Manhiça district I analyse both the characteristics and delivery of indigenous medicine and the representations of, and meanings attached to it by different stakeholders.

My thesis is that indigenous medicine is a form of medical knowledge and practice that represents its illness, therapy and efficacy according to specific epistemological foundations, rooted in the local society and culture. Yet it has been misrepresented by local discourses, agencies and practices that battle to control health resources, knowledge and power. Biomedical health paradigms, bodies, and representations have been imposed onto an imagined biomedical health space. People, on the other hand, undermine this rationality through representing, legitimising, and seeking therapy simultaneously in different epistemologies and practices of medicine within the therapeutic landscape. This political economy of health is contingent on historical, socio-economical, political and geopolitical productions and constructions of health and efficacy within Mozambique's public health field. Research and health development needs to rewrite the historiography of indigenous medicine based on ethnographic sensitive material and linguistic competence.

CHAPTER II - THEORETICAL AND CONCEPTUAL APPROACHES

2.0. Introduction

Throughout this chapter I review the existing (anthropological) theoretical frameworks and approaches used to analyse illness representation and efficacy in medicine and indigenous medicine in particular. I intend, through this review, to then establish the appropriate theoretical and conceptual framework to analyse the research material and questions addressed by this study.

The research questions raise issues about the ontology of illness and health. They also highlight the need to inquire about ‘what heals’, and identify the locus and models of efficacy. The problematic issues raised in the research questions are also reinforced by the power relations that influence the notions of truth about what is medicine, especially indigenous medicine, as a body of knowledge, in the plural health context. This chapter will therefore focus on illness representation, issues of medical pluralism, and political economy of health.

2.1. Illness representation

2.1.1. Illness representation as folk belief

In early writings, the discipline of anthropology was interested in studying other societies and paid special attention to “exotic” (colonial) settings. The study of other societies included an all-encompassing anthropological interest in the analysis of illness as it was found to be one of the most prominent parts of the cultural practices under scrutiny. Some of the celebrated studies of the time are Malinowski’s (1922) research *Argonauts of the Western Pacific*; Rivers’ (1924) *Medicine Magic, and Religion*; Evans-Pritchard’s (1937) *Witchcraft, Oracles and Magic Among the Azande*; and Junod’s (1996 [1927]) extensive monograph in the south of Mozambique; *Usos e Costumes dos Bantus*²¹. These are among the most important modern anthropological texts elaborating on indigenous medicine in non “western” settings, and are very rich in their

²¹ Usages and habits of the bantu people

ethnographic interpretation of local explanations of illness, health and misfortune. However, as with other research conducted in Mozambique at that time (see Earthy 1933; Ferraz de Freitas 1957; Rita-Ferreira 1960, 1966, 1967/68; etc²²), Junod's approach appears outdated in its use of functionalist and evolutionist explanations, and in the ethnocentrism of this, which is methodologically inadequate for portraying people's experience. Functionalists and evolutionists conceived local cultures and societies as being 'logical' but static in comparison to their western counterparts that progressed further in their rational way of representing sicknesses as empirical biological entities residing on the physical body.

These writings were based on the concept that the indigenous reasoning about health and illness did not represent the empirical world as it did not use the logic of "western" medicine. Then the term *belief* became the language through which representations of illness beyond biological entities were discussed (Good 1994). Does this term have counterpart in local indigenous medicine? Byron Good, following Needham (1972) and Smith (1977), argues that *beliefs* are sets of propositions that rationalist thinking judges more or less true depending on the adequacy of their ostensive representation of the world. Western science displays an unfounded arrogance in its assumption that science "knows" while the non-western "traditions" only "believe" (Pp 15-17). He considers that knowledge requires both certitude and correctness while belief implies uncertainty and error or both. Inappropriately attributing the term "belief" to others, is a 'western' concept that has come to connote "conviction to a given idea or principle" within the modern context. This way, rational empiricist reasoning claims superiority over other epistemologies.

More modern studies of illness representation in medical anthropology have their roots in applied research for public health after the Second World War. The post war tradition had to respond to poverty and health problems provoked by the destruction of Europe. This incited an interest for

²² See Kirchner (1990), collection of texts on indigenous medicine in Mozambique.

anthropological expertise to help deal with people's 'resistance' to health interventions (Alexandrakis 2001; Cawdill 1953). This applied health research endures in modern interventions in developing countries in which anthropologists collaborate with biomedical health services in the understanding of the poor in order to facilitate the delivery of health programs such as vaccinations, family planning, and nutritional campaigns. Here medical anthropology has a tendency to highlight the cognitive disjuncture between the 'traditional' and biomedical forms of reasoning. The understanding of public health professionals being that the local opposition to biomedical health services is a form of irrationality resulting from ignorance and erroneous views about health and sickness, and that anthropologists can be called on to mediate between the two worlds (Morsy 1996; Pool & Geissler 2005). Similar problems are being faced by psychologists who, in order to respond to the problem, have changed the term indigenous 'beliefs' and, developed the *Health Belief Model* which is still in vogue in health planning and interventions around the world.

The *Health Belief Model* is widely used in Mozambique by health planners and academics as a tool to represent illness, yet the concept of '*beliefs*' has no ontological validity or philosophical foundation, undermining its analytical strength. It produces narratives that are detached from both indigenous medicine practices and from the therapeutic context in which the *tinyanga* practice. Indigenous representations of illness are from the perspective of biomedical stereotypes within a derogative vocabulary that highlights the history of colonial and postcolonial construction of the inferior *other* in Mozambique. As a result of this approach, indigenous medical practice is known as a concatenation of irrational reasoning, beliefs, superstition, ignorance, and magical practices, judged as such on the basis of biomedical standards.

2.1.2. Cognitive approach to illness

Research in cognitive anthropology has long been interested in the way in which people categorise events and objects in context. With this in mind, the subfield of medical anthropology

has represented illnesses in semantic terms as devices that were provided by culture. The most common variant of cognitive medical anthropology inquired into cultural models of particular health disorders, their intercultural variation as well as people's agreement about them within particular cultures (See Green 1994; 1999).

Later research in this tradition shifted its focus from a more structural linguistic inquiry into illness to one that looked at the contextual characteristics. The contextual narratives were defined as the stories or plots that patients, healers, their friends and relatives tell about sickness using metaphors, and rhetorical devices (Belliard & Ramirez-Johnson 2005). Oral accounts concerning sickness give shape and structure to the illness as culturally and individually experienced.

Taking into account that medical "systems" use the ideology within language (combining both referential and social meanings of language) to represent and legitimate their knowledge, the semantic terms or terminology studied by the cognitive school play an important role in nominalisation and sickness classification which is the entry point for the construction of the wider discourse about medicine and constitution of health seeking practices²³.

The improvement introduced by the cognitive approach to the structural analysis of illness suited biomedical views which also represent a direct correlation between linguistic devices and bodily pathologies. They then overgeneralised this, applying it to other medical traditions. In Mozambique, the medical anthropologist E. Green examined the representation of sickness of indigenous medicine in his study *Indigenous theories of contagious diseases*, using this approach to illness representation. Indigenous models of healing, he asserts, are akin to the biomedical ones. He considers indigenous medical terms associated with "pollution" and their social prescription as similar to the biomedical models and theories (Green 1999). Relying solely on

²³ Linguistic practices convey and construct social reality but are also constitutive of that reality which means that they are not isolated from each other (Duranti 1997; Firmino 2005; Saville-Troike 1982)

interviews, and without presenting any ethnographic material to support his claims, he concluded that the concepts in indigenous medicine for bodily sickness such as *nyoka* and *nyokana* were “(...) symbolic expressions of the need to respect the human body – even as a personified immune system.” (p93). He viewed them as semantic devices, with no appeal to pragmatic and social dimensions, in which the epistemology, meanings given by and understandings of the actors play a central role. Green’s work ignores the fact that *health beliefs* or *metaphors*, as he calls them, do not match with what people do, such as the healing techniques and modelling of efficacy. Illness representations are here seen as formal cognitive structures without any consideration being given to the local dynamics and reasoning behind these terms vis-à-vis their therapeutic process. Green’s conceptualisation of indigenous medicine also dismissed the broader cultural and social dimensions of health and healing. It looked at indigenous medical practices with a biomedical gaze and applied its empiricist theory of language. He confined different sicknesses into semantic terms and ascribed them as metaphors. As Kendall (2000:630) asserts, Green’s study is

“(...) a concatenation of African health beliefs, contagion ideas, and traditional healers; a codification of these ideas into a "theory" meant to parallel germ theory (a Diagnostic and Statistical Manual for the traditional medicine ethnological enterprise?); and a claim of efficacy built on the similarity of indigenous contagion theory to germ theory rather than on its therapeutic effect (...)”.

Cognitive medical anthropology has continued to focus solely on referential meanings of language in analysing illness representation, excluding the historical and social constitution of sickness. It has also continued to have the methodological problem of contextual detachment of the terms represented, and the perspective associated with this, as outlined above. This is not an appropriate approach to frame this study because it is reductionist in the way it represents illness.

2.1.3. Illness as a cultural reality

The meaning-centred approach to illness represents the emergence of medical anthropology as a systematic and theoretical field of inquiry by placing the medical system as a cultural system, and putting it at the centre of the anthropological object of analysis (See Good, B. & Mary-Jo Delvenhio Good 1985; Kleinman & Sung 1979; Kleinman 1980). Representing sicknesses as cultural realities and symbols, these authors shifted their attention from narrative structures to what they called explanatory models encompassing the way therapists, patients and their families represent the different types of sickness, their aetiologies, symptoms and treatments in therapeutic contexts and semantic networks. This approach argues that the explanatory models can be found in popular, folk and professional medical sectors (See Kleinman 1980). For Arthur Kleinman the professional sector encompasses the official and bureaucratic biomedical public health, which in some countries like China and India may include the local Ayurveda and acupuncture. By 'popular sector' he means popular knowledge about and experiences of health, and the folk or traditional sector, is the non-bureaucratic, unofficial practise of indigenous medicine. By adopting this approach and elaborating on illness representation within this school of thought, medical anthropology makes a strong distinction and mediation between emic and etic views, and the contrast between disease and illness in understanding health and healing. The emic perspective is said to reflect the viewpoint of the local people; worldviews that are captured and made meaningful to anthropologist researchers; whilst the etic perspective privileges the viewpoint of those observing, normally associated with the vantage point of the current scientific theories (Pool & Geissler 2005). Within this positionality and hierarchy, disease is conceived as the objective reality of the physical pathology and illness as the subjective experience of suffering, culturally bounded to such an extent that patients can experience disease without having illness and illness without any symptoms of disease (see Eisenberg 1977; Young 1982).

The distinction between emic and etic in this context can be questioned when supporting assumptions that the knowledge of those we study is less true and valid than ours. When biomedicine is thought to be scientific and neutral then its propositions are imagined to be etic, and all other forms of reasoning in local medicine are considered emic. In this distinction, science and reality are fused as one, ignoring the fact that medicine is itself culturally bounded and so undermining the possibility of using the scientific tools to inquire into all forms of reality. Likewise, the counterpart distinction of disease vs. Illness also does not properly inform anthropological inquiry into illness representation since it disproportionately supports too much the biomedical agenda by assuming the absence of culture in biomedicine. The dichotomy between disease and illness implies that the lay sufferer has (illness) culture and medical professionals have (disease) objective knowledge (Janzen 2002; Pool & Geissler 2005) creating the erroneous idea that other medical traditions, confined into folk and popular sectors, have no bodily sickness. Basically the positive view of a human body dispossessed from culture, and certain notion of personhood informed by the systemic biology that informs biomedicine are used as paradigms through which sicknesses are classified. As Rhodes (1996) asserts, this representation of health disorders risks medical anthropology taking on the characteristics of biomedicine itself. The formulation of disease vs. illness leads us, on the one hand, to a sort of universally homogenous bodily representation of suffering, which should be (ideally) experienced the same way in every societies and medical traditions. On the other hand, it directs us to a cultural representation of suffering (illness) confined exclusively to non-biomedical traditions. The distinction of disease vs. illness is not therefore a useful way to frame the way indigenous medicine in Mozambique represents sickness.

African anthropological literature tends to view illnesses in a rationalistic way by classifying them in terms of normal vs. abnormal, natural vs. supernatural, naturalistic vs. personalistic, and religious vs. social (see Chavunduka 1986; Foster 1976; Green 1999; Monteiro 2011; Ngubane

1977; Westerlund 1989). These approaches assume that indigenous medicine's aetiology of illness can be categorised, for example, in terms of "natural" and "supernatural", where "natural" aetiology is caused by "natural" conditions and humans, spirits and witchcraft originate "supernatural" causes. These Africanist anthropologists continued with the problem of dichotomising sicknesses identified in the previous cultural studies of medicine. Their approaches are also inadequate for framing the illness I encounter in the field. My understanding is that the spirits of those who passed away are placed into the same social context, as human living beings and that the so-called abnormal and supernatural illnesses are also socially and historically embodied by the sufferers. As we shall see, people in Maputo and Manhica make no separation between living humans and their deceased ancestors in social practices and afflictions.

In Mozambique, anthropological literature on illness representation apparently avoids the terminologies above (See Honwana 2002). Alcinda Honwana categorises simple and complex illness, and argues that these two categories reflect better the way people from the south of Mozambique²⁴ view illnesses. According to Honwana, simple illnesses, for example coughs, light fevers, headaches etc. are regarded as such because they are known to be provoked by causes like germs, bacteria or bad nutrition. They occur normally and have a transitory nature in peoples' lives. Furthermore, they can be treated with medical treatment that involves either herbal or chemical remedies, or life-style changes that can either be carried out by indigenous or biomedical health providers. She goes on to assert that when a simple illness persists and begins to affect the life of the person, it comes to be considered serious and threatening – not only for the individual suffering directly from the illness, but also for their family members. At this stage, the illness is considered a complex one. Here, individuals consider that such diseases can be attributed to three factors: to the action or power of the spirits – either ancestral or malignant spirits - to witchcraft, or to the unjust manipulation of ecological conditions by humans. The cure

²⁴ Including these from my research site

of such an illness must, therefore, involve strategies that go beyond biomedical remedies directed strictly to the physical body of the sufferer.

Honwana's terminology – simple and complex – assumes, questionably, that biomedicine only deals with simple ailments, while indigenous medicine can cope with complex ones. This is mistaken since any medical 'system' is both complex and simple in its own way. She also continues to use the very binary distinctions that have been used by others to reinforce separation between bodily illness (considered to be biomedical or from the professional sector) and cultural ones (from indigenous medicine or folk sector). In other words, she has just changed the terminology while being caught in the trap of the same empiricist and rationalist theories. She created one dichotomy to try to overcome others and consequently reinforced the existing theories yet again. Do people in Mozambique recognise the different aetiologies of illnesses mentioned above? Do they put illness into binary categories?

The focus on the study of referential categories, cultural specificity and dynamics tried to improve the anthropological understanding of local forms of health and sickness. However this meaning-centred approach has been criticized by the forthcoming approaches for neglecting, *inter alia*, relations of power and the way they mediate and constitute the social and economic fabric of health, sickness and therapy.

2.1.4. Critical Medical Anthropology

In the last decades a critical perspective to medicine has emerged claiming that the health space is an arena of power struggling that can conceal forms of domination, injustices and suffering (Rhodes 1996; Scheper-Hughes 1992). Critical medical anthropology has severely criticised other anthropological approaches that were bracketing out political and economic factors concealed inside this form of misrepresentation of health/illness. Nancy Scheper-Hughes, in her study *Death without weeping: the violence of everyday life in Brazil* shows how medical treatments with

tranquilisers are in fact medicalisation of starvation and malnutrition. This approach also moved beyond the illness/disease dichotomy when inquiring on illness/health representation - whether of indigenous medicine or biomedicine – and saw it as something that represents or misrepresents power relations. Instead of focusing on cultural symbols and referential categories, this approach places greater emphasis on the representations of ideologies of the political and economic interests and on social inequalities that shape health/illness representation (Baer et al. 1986; Scheper-Hughes & Lock 1987; Singer 1989). For critical medical anthropologists, medicine should not be seen as separate from the social and economic power relations within the wider society, since the way health and illness are represented reflect social contradictions and inequalities.

Critical medical anthropology is pertinent to analyse ‘medical pluralism’ in Mozambique since different medical traditions are confined into different health planning spheres in which they acquire different meanings, and where indigenous medicine is misrepresented by current forms of power, including academic thinking. From a critical stance, the very distinction between illness and disease, or simple and complex, reflects the way anthropologists themselves impose their own power/knowledge and biomedical forms of reasoning over the definition of sickness, without any mediation with the particular health context or with human suffering in general.

Regardless of its contribution to the analysis of illness and health, critical medical anthropology has some paradoxes vis-à-vis its critical attitude. On the one hand it has been using the ideology of the language of biomedicine to criticize inequalities and power relations in different forms of medicine. Scheper-Hughes (1992), for example, relies on biomedical terms to address the misuse of pharmaceuticals on hungry people in Brazil. However, this country, especially the context in which she conducted her research, is known to have different medical practices rooted in colonial migration and slavery. Surprisingly, on the other hand, this critical approach has not been paying attention to issues of stereotyping and the degrading of indigenous medicine which

continues to be described in terms of beliefs, magic, and divination, with the assortment of *tinyanga* being put into the same sack called indigenous healers or diviners. Yet this very vocabulary is silencing the majority of Mozambicans who use and practice indigenous medicine. If 'critical' anthropology is still doing this, what can medical anthropology do about it? How can this derogative language be dealt with in a context where many people who use and practice indigenous medicine do not have the power that I have to speak about it? If this affects me, then it is likely that some others may be feeling the same as I do but (many) have no channels or voice to complain. I find Leslie (2005) useful for addressing this problem in the way he understands the agenda of critical medical ethnography. He argues that it should encompass three key principles: The *anti-inequity* agenda, which argues against the injustices, hegemonies and capillary power relations that disenfranchise and harm people, *reflexivity*, which stresses the need for self evaluation, since we are all embedded in socio-cultural systems that influence the way we conceptualize and mediate the world, and lastly, *refiguring of the anthropological subject*, which mainly rejects the misconception that the people we study are indigenous, ethnic, other and exotic.

There are others within the approach under analysis however, who still show a juxtaposition between the biomedical knowledge and anthropological perspective in relation to representation of health/illness and management of therapy, transforming the inquiry of medical anthropology into a sort of arbiter of "good" and "acceptable" practices of biomedicine (See Jordan 1989). In order to give a voice to the epistemologies of indigenous medicine in medical pluralistic contexts, it is important that we treat biomedical typologies as one among other repertoires of illness representation locally available rather than assuming them to be foundational conceptual categories.

Critical medical anthropology has also typically privileged political and economic factors of illness when analysing the (mis)representation of health: i.e., the line of approach taken has become a

misrepresentation of illness. This could be avoided if medical anthropology also examines the biological, ecological, cultural and historical factors stressed by other medical anthropology perspectives.

2.1.5. An integrative approach to illness representation

A critical stance of the perspectives above offers the possibility of moving towards an integrative approach to medical anthropology (see Joralemon 2006; Janzen 2002; Staiano 1992a; 1992b). This would have to look at biological, social, cultural and political factors that shape health and illness. These factors are interconnected and can be described as “(...) Phenomena of different levels that are neither entirely determined by nor entirely autonomous of each other. For example, lower-level physiological phenomenon, such as blood, genes, cells, and body organs, constraint the functioning of high-level phenomena, such as thought, culture, and society, but high-level phenomena may affect lower-level ones as well.” (Hahn 1995:74).

Janzen (2002) postulates that sign theory may help medical anthropology span the dichotomies and disjunctions of the biological and cultural in the study of health/illness. Signs are known to vary in the extent of compulsion associated with “(...) the sensory part of the sign to its objects and its meaning, its significance. This variance or “continuum” may range from full compulsion or necessity to a totally arbitrary association” (p45). A second property of the sign, he continues, is the ongoing process of *semiosis* which establishes that the relationship of the sign to its objects and its meaning changes continuously as is the case in illness/disease. This process may “move from a close association of necessity to one that is arbitrary, or both conditions, or degrees of the two, may co-occur” (p45). For example, in spirit possession the relationship between the host and the guest, or the biology and the culture, gets blurred; in marital disruption, misfortune, loneliness, and stress, the social and the biological are linked in health, illness and healing; and in malaria or cholera, both parasites and socio-economic conditions of their development are involved and may be responsible in different degrees for the suffering.

From this perspective, as with the sign, illness mediates between the object, culture and society to the extent that in sickness and suffering the inside and outside of the body are a unitary whole (Daniel 1984, Staiano 1992a; 1992b). An understanding is taken from this that sickness can have an arbitrary relationship to the body or to culture and that this association to one or the other can be made out of pure necessity or it can be a mix of both. An appropriate approach to illness representation must therefore conceive of illness both as a means through which socio-cultural and bodily distresses are expressed and as a constitutive element of both bodily and/or socio-cultural anomalies. The representation of illness should be seen through a continuous process of interaction and interconnection between history, physical body, culture, and society. The consideration of these meanings brings medical anthropology back to the holistic understanding of illness in health and healing as well as to a theoretical analysis of illness that is feasible across medical traditions.

2.2. Models of Efficacy

An anthropological examination of medicine offers a good explanatory adequacy if, rather than only looking at the way people represent illness, it spans to the relationship between health, illness, and healing/therapy. In health fields, the desire is to have healthy people, yet illness is an ontological constituent of human experience; when it comes therapy is sought. The therapeutic process however must not be considered to guarantee a result per se, but instead as a means for restoring health which may fail or succeed. How healing works or fails in its attempts to engender the change from illness to health is what the concept of efficacy entails. Illness representation is strictly related to, and must be viewed in relation to, the therapeutic strategy to heal (model of efficacy) as well as to how and where this configuration works in order to engender transformation and alleviate people from suffering. Medical anthropologists have inquired into how healing works (and fails) but there is no consensus on what the locus of healing is. Csordas and Kleinman's (1990) have categorised different models of efficacy as structural; social support;

clinical, and persuasive. The structural model locates the efficacy at the levels of body/emotion/cognition or person/society/culture (See Levi-Strauss 1968). The social support model locates the healing and efficacy in the group as in Turner (1967; 1968) and Janzen (1978b). Turner's work demonstrates how the Ndembu people from Zambia place the whole group of kin and ancestors of the patient as the locus of the therapeutic strategies. Then later, in his research in former Zaire (currently DRC), he also highlights the notions of "*Therapy management* (diagnosis, selection, and evaluation of treatment, as well as support of the sufferer) and the *therapy management group* (the set of individuals who take charge of therapy management with or on behalf of the sufferer)" that constitute the model and locus of efficacy.

The clinical approach focuses on the illness and treatment of singular individuals, and on definitive outcome (see Prince 1964 study on 'Yoruba psychiatry'). It is a clinically-based model in which the locus of efficacy is the biological body. Biomedical encounters stress this model of efficacy in their principles and ways of producing knowledge. The persuasive model assumes a critical position to the first approach that analyses the healing process, for example the ritual as a text - a semantic device – arguing that the ritual is not just a text but also a performance. Viewed thus, what unites the therapeutic process - for instance the ritual involving spirit possession - and makes it achieve positive outcomes are, *inter alia*, the engagement of the group in the interpretation of the therapeutic encounter, the spirit's management of the artistic devices and acceptable sequences of the event, the charisma of the therapist or spirit/medium (Schieffelin 1985; 1996), as well as the ability of the spirit to control the mood and interests of the participants.

Csordas & Kleinman (1990) argue that the four approaches are not mutually exclusive in practice but that methodological dispositions and the diversity of different forms of healing force inquiry to take a diversity of analytic emphases and rely on a specific model of efficacy. The four models of

efficacy can co-occur in different medical traditions but local contexts shape the most important healing practices for local experience.

There have not been anthropological studies on models of efficacy in Mozambique. Research projects on indigenous medicines carried out in different settings in Mozambique focus on biomedical and pharmaceutical oriented studies of efficacy. These clinical approaches to efficacy and the intention of making them appropriate to indigenous medicine have not been productive so far. Medical anthropologists have also been conceiving and operationalising the efficacy of traditional medicine within 'western' and biomedical methodological and epistemological assumptions instead of exploring and comprehending how efficacy is conceptualized and understood within indigenous medicine itself (Waldram 2000). It has also been argued that this tendency to judge practices of other medical traditions in terms of measures of efficacy based on the rationalist empiricist theory of the biomedical sciences is not reasonable because is not neutral and value free but entail relations of power. Yet when it comes to decide which models of efficacy are valid it can be questioned who decides what constitutes evidence, and what sources of information and epistemologies are privileged as well as ignored (Nichter 1992; Nichter & Lock 2002).

The different notions of efficacy are associated with the notion of personhood among the practitioners of a specific medical tradition. The biomedical approach to sickness sees the individual as an autonomous, separate and independent entity and this shapes the way illness is represented, therapy directed and the efficacy sought. Yet indigenous medicine can typically understand the person as a dividual and relational entity (Pool & Geissler 2005; Strathern 1988); a social person that is constituted through its relationship with other persons, ancestors and the ecosystem in the dynamic of the social practices. This notion of personhood configures the representation of health/illness and the loci of efficacy.

To counteract the biases inherent in the utilization of biomedical understandings and methods that characterises much previous work, medical anthropologists have suggested returning to the field to improve its understanding on how indigenous medicine models of efficacy work and heal effectively (Waldram 2000). This research therefore examines the models of efficacy of indigenous medicine taking local epistemologies seriously and focusing on the experience of those who use it.

2.3. The notion of ‘medical system’

The concept of ‘medical system’ is directly related to the definition of the notions of health and sickness since it sets up the framework in which the representations and knowledge about health and illness are organised, and therapy is demanded. An improved understanding of the debates surrounding illness representation is inextricably associated to a clear definition of the term ‘medical system’.

It is said that Mozambique’s public health and the social context of therapeutic choice is that of a medical ‘syncretism’ in which patients weave in and out of indigenous medicine, biomedicine, and other Asian indigenous medical traditions²⁵, establishing multiples relationships with different health paradigms. It is estimated that more than 60% of Mozambicans rely exclusively on the former to satisfy their healthcare needs and 40 % have access to both (Governo de Moçambique, BR nº 15, I Série de 14 de Abril de 2004). In order to grasp the ecological, biological and cultural factors that shape the representation of illness in this context, as well as the macro economic and political relations and dynamics that inform them, it is important to clarify the nature of the entities in which health is sought, the body of knowledge about illness is upheld, and in turn put into a political economy. I will review some of the approaches that try to understand where people go when they feel sick or suffer from misfortune. What is a ‘medical system’ in relation to our

²⁵ Mainly Ayurveda and acupuncture

understanding of indigenous medicine or biomedicine?²⁶ Is it the way we give it a living form that is useful to inquire on illness representation and on people's quest for therapy? Which approach better suits the need of this dissertation when engaging with the illness representation and political economy of health in an ontologically valid way? These are the questions that I aim to address.

2.3.1. System approach

The *System approach* conceives that the context of therapeutic choice is build up by bounded medical systems with a real existence as entities. People use them to respond to their health problems. The use and coexistence of the systems, generally named conventional medicine (for what we have been naming biomedicine) and traditional medicine (indigenous medicine), is conceptualised in terms of the bifurcation and integration of health care coverage through cooperation and communication between the coexisting systems (see Governo de Moçambique, BR nº 15, I Série de 14 de Abril de 2004; Sambo 2003; WHO. 2002). This integration of health services in African countries, the systemic approach argues, takes four main forms, namely the monopolist, tolerant, inclusive, and integrative systems (Sambo 2003). In the monopolist system, which is no longer reported in the region, only biomedicine is authorised and all other forms of medicine are banned and chased underground. Also called exclusivist system, it only accepts the professional and legalised orthodox medicine (biomedicine) practiced in mainstream hospitals and clinics and deems all other medical traditions peripheral, unofficial and in many cases illegal (see Janzen 2002; Last 1990). The tolerant system legislates that only biomedicine may practice but allows indigenous medicine to be exercised but without any formal recognition. The inclusive system conceives of distinct bodies of medicinal systems in health care delivery and choice. Here

²⁶ Taking into account the need humans have for nominalisation I feel I will put myself into a corner! This paradox between conceptual validity and linguistic praxis will be evident in the dissertation. How to name a concept that does not fit in a term?

both systems are officially recognised and the state designs a policy of indigenous medicine that deals with its regulation and legislation. Sambo (2003) mentions Mozambique as one of the countries where this system has been adopted. Lastly, the integrative system, also exemplified by Janzen (1978a) from China, India and Vietnam, is characterised by a full recognition and whole incorporation of both medical traditions into the Official National Health System (ONHS).

These conceptualizations are made from the perspective of the health planners, and 'from the top' instead of from within the context of the health delivery itself. They are prescriptive and functional assuming that the systems have a macro static form and that choosing them is rational. This approach is akin to the Radcliff-Brown's (1962/65) structural functionalism, which conceives that any system has a structure whose parts work to maintain the whole. This structure, he asserts, is comparable to anatomical and physiological systems. It is the role of the organs to keep the body running. This approach assumes that the therapeutic choice is a straightforward process of using exclusively these components of the system. It only looks into local legal and political frameworks and not the dynamics of the context. The approach, since it is biomedically oriented, stresses the opposition between spirit and matter, mind and body²⁷, and (underlying this) real and unreal, natural and supernatural, nature and culture. Diseases as defined above can be located in the mind or the body. Then illness is cast as "abnormalities in the structure and/or function of organs and organ systems" (see Eisenberg 1977); and medical system as the apparatus designed accordingly and in order to respond to the needs and shape of this structure²⁸.

By focusing on systems and legal frameworks, this approach builds a normative and static notion of medical tradition and therapeutic choice that fails to understand what people do in the context

²⁷ First established by the philosopher-mathematician Rene Descartes (1596- 1650) who actually formulated the ideas that are the immediate precursors of contemporary biomedical conceptions of the human organism.

²⁸ If we one looks at the organisation of the hospitals in Mozambique and elsewhere for example will clearly figure out that its organisation reflects the organs of the human body.

of their day to day lives when questing for therapy, and where they go when they are sick. For example, in the Mozambican revolutionary post-independence state, that adopted a monopolist system, in spite of the persecution of indigenous practices by the socialist regime, *de facto* people chose it among the available medical practices. The perspective also assumes the health systems are natural and disembodied from relations of power and status. The system approach takes for granted the differential use of the existing medical traditions by the modern state and ignores the debates about their social meanings and power relations. It does not account for the fact that the adoption of biomedicine for health delivery and its development was historically contingent.

The other problem posed by the system approach is the passive use of terms like *conventional* medicine and *traditional* medicine. Where and for whom is it conventional medicine? Can it be conventional in a context in which more that 60% of the population have no contact with hospitals? The way this approach refers to categories such as traditional medicine and modern medicine without theorizing on this distinction, or notions, may suggests that the two categories are opposed, static vs. dynamic, changeable vs. unchangeable.

2.3.2. Medical pluralistic approach

The syncretic utilization of different medical traditions within one geographical settings or one medical 'system' is acknowledged in different studies (Janzen 1978b; Kleinman 1980; Last & Chavunduka 1986; Leslie 1980a; Pool & Geissler 2005). This work on medical pluralism recognizes that when people quest for therapy in a context of pluralism, they make simultaneous use of different therapists and health alternatives. The availability of different health alternatives, for bringing about or maintaining health, gives power to patients to choose from a variety of therapeutic options. Therefore, when searching for health services, patients make decisions between the existing medical varieties. As in other medical pluralist contexts in the world, the

Mozambican patients are pragmatic in their medical 'syncretism' and see nothing inconsistent about combining different medical practices in their quest for therapy.

Charles Leslie's contributions to the documentation and critical interpretations of medical pluralism in Asia stress that the notion of medical 'system' is a result of ordering and systematisation brought about by the modernization processes of biomedicine and world health planning (Leslie 1980a). He also notes that advocates of the system approach have been (incorrectly) assuming that biomedicine would oust indigenous forms of medicine worldwide and becomes the standard healthcare service, encompassing some indigenous aspects deemed positive in the eyes of modern science. However, cultural, economic and historical factors have incited pluralism and complementarities in the contextual utilisation of therapies and relief of human suffering (Leslie 1976; 1980a).

The dualism of medical systems in terms of modern medicine and traditional medicine has been challenged worldwide with the evidence and argument that all forms of medical knowledge are dynamic and change over time as the result of processes of social change, diffusion of knowledge and technological innovations. The other epistemological contribution of medical pluralism theorists is that indigenous medicine practices are usually open to new forms of reasoning and knowledge, as can be subject to scientific scrutiny (Leslie 1992).

In considering the therapeutic choice, this approach takes an alternative perspective by looking beyond structures and into social practices, and focusing on the different strategies undertaken by people when seeking health. It rethinks the concept and implementation of medical pluralism by shaking the functionalist²⁹ oriented approach that suggests bounded and disjunctive

²⁹ Functionalist theory and factionalist oriented approaches sees society as a unitary whole made of components that structure the system and contribute to its maintenance. The components of the system are balanced and make up the whole. For example the human being is a system constituted by its internal parts that function to maintain the whole (Thomas 1985), its interaction with the ecology is generally not considered.

biomedical health care services and knowledge. As Last (1981) would point out, what is thought to be 'medical system' is, in fact, a 'non system' that encompasses different medical practices and epistemologies very often used simultaneously by patients. Even those health care sectors suggested by Kleinman (1980)³⁰ are not distinguished in the perspective of the patients. In his study *The Quest for Therapy: Medical Pluralism in Lower Zaire*, Janzen (1978b) found out that in this African context, which is akin to many other sub-Saharan African societies, the group of relatives that manages therapy (*therapy managing group*) was key for understanding health services and health delivery since they are the ones who have to reach a consensus about the therapy and the health care to be chosen. There are other ethnographies in Latin America that put the patients at the centre of the definition of 'medical system' due to the way in which they in fact shape it as social practice (see Jimenez 1995; Belliard & Ramirez-Johnson 2005, Spector 2000). The 'medical system' is just a conceptual (heuristic) device that we use for analytical proposes but is never an image of the reality we study.

A perspective of medical pluralism does not see medical traditions as static elements, nor does it dichotomise the choice of therapy. Instead it recognizes that from the patients point of view there is a single corpus of illness which available healers should manage between them (Last 1981). Taking a page from Pool & Geissler (2005) it can be said that when one looks at what people really do when they are ill or suffer misfortune, one finds out that they undergo a creative process questing for therapy in which invention, innovation and disorder play an important role.

³⁰ As aforementioned Kleinman (1980) suggests three sectors of medical systems that he assumes they deliver health care services. Namely the professional sector, the folk or traditional sector and popular sector.

2.3.3. Therapeutic landscapes

Regardless of the fact that the medical pluralist approach recognises 'syncretism' and the role played by patients in shaping the health practices, it has been criticised by still implying that two distinct entities are merged. Some anthropological work in Africa questions the pertinence of these distinctions in local health seeking experience, arguing that the distinctions between traditional medicine and biomedicine is outdated in the modern African therapeutic contexts, and only make sense from the vantage point of health professionals (See Gordon et al 2005; Leach et al 2008). They suggest that other distinctions and constructions are becoming far more important to the ways that people evaluate their health experiences locally.

In order to mediate the problems posed by the concepts of 'medical pluralism' and 'medical systems', questions on whether the two medical approaches are separate entities or are intertwined are abandoned and the concept of 'therapeutic landscape' unfolds. Therapeutic landscape refers to health and healing knowledge, practices and experiences of specific groups of people in a particular place (Gesler 1992; Madge 1998). They are seen as material and symbolic, constructed through and constructing social practices and processes (Leach et al 2008). Medical landscapes typically encompass varieties of medical practices that form repertoires with different degrees of (dis)similarity.

The notion of therapeutic landscape is one of the significant contributions to the study of therapeutic delivery and choice, and is suitable to capture the *praxis* and explain the relations between different forms of medical knowledge and practices by looking at those who experience them and how they respond to local social and historical dynamics. Further, it stresses the importance of looking at the way people represent health delivery and choice as well as at the categories that emerge from this experience. In considering these assumptions, this dissertation is interested in understanding what sort of health and healing categories, therapeutic expertise, and forms of solidarity emerge from local therapeutic landscapes in Mozambique?

2.4. Political economy of health

The interpretation of medicine must simultaneously involve the consideration of the political context in which it is practiced. The way health, illness, efficacy, and therapeutic choice are represented is not just confined into cultural symbols and in the therapeutic landscapes but also shaped by social and economic dynamics and by national and international power relations. In the next sections I present the relevant explanatory framework regarding the political economy of health in medical anthropology in order to frame this dissertation.

2.4.1. The public health field

I borrow the notion of field from Bourdieu (1990b [1980]; 1996) who uses it to refer a specific space of social relations in which individuals and institutions are positioned and position themselves according to their agency. There are varieties of social fields that can be conceptualised according to the object in analysis. By *public health field* I mean the space in which individuals, cultural agencies, and social institutions use or are subject to different forms of power to legitimise their medical practices and the resources they use to deliver them. The underlying assumption is that the local cultures that encompass medical practices are managed or legitimised by social institutions and agencies, and the relations of power are intrinsic to this management. With the notion of field, medical anthropology can improve the understanding of the multifaceted relationships between patients and therapeutic landscapes, especially how individuals and social institutions battle for the recognition of their health and healing knowledge, practices and experiences, as well as how some of these are more legitimated than others.

A good starting point to conceptualise on processes of social legitimisation and positioning are the Pierre Bourdieu's notions of *social*, *cultural* and *economic capital*, and *symbolic violence* used to expose the dynamics of power relations in social practices. Contrary to the classical political economists who focus purely on economic terms, he conceives the notion of capital as more broadly social, encompassing the economic, social, and cultural capitals that people use to

compete with each other and to distinguish both themselves and their social practices. Economic capital is the accumulation of different forms of material wealth, while cultural capital is the information (intellectual and artistic qualifications) that people gather. He calls social capital the existing or potential assets the individual or a group has according to its networks and relationships (Bourdieu 1990 [1980]). These three forms of capital become symbolic capital – meaning that it has specific symbolic efficacy – when it is ‘misrecognized in its arbitrary truth as capital and recognized as legitimate’ (Bourdieu 1990: 112, in Samuelsen & Steffen 2010). Since positions in any social field depend on the type and power of the capital possessed, the legitimisation and recognition of health and healing knowledge, practices and experiences held by a particular group of people will be influenced by their relative symbolic capital and how they use it. However, as Bourdieu (1996) observes, the (public health) field has to be seen as a dynamic setting where the production, meanings and values of the different types of capital are in constant change. In fieldwork conducted in Uganda on local understandings and strategies for health, Meinert (2010) explores the use of the concept of capital and demonstrates that all forms of capital come into play when local people quest for health and fight to position themselves in the field and distinguish themselves and their social practices.

In the public health field, the legitimate medical practices are defined according to, or reflect, the relations of power between social institutions and agencies that uphold local representation of health and illness. The social history, meanings, (perceived) competence and authority, and resources will produce unauthorized and authorised medical practices and position those who use them. But the intrinsic characteristics and efficacy of the medical practices have little to do with the way in which they are positioned along with their users in the public health field. This means that what makes a particular medical tradition or illness representation valid are the local forms and conditions of social production. Samuelsen (2004), for example, finds out that positions in local health field in Burkina Faso are not merely obtained by the experience of sickness that

people have but by the influence of their symbolic power. The wealth, learnedness, smartness of local families play major role in influencing the positions within the field of health.

However the validation of health and illness representation may be through the use of power conferred by a sort of symbolic capital (political or economic for instance) by those who control the means and modes of production. This symbolic violence (Bourdieu 1984) might mean the imposition of paradigms upon those in vulnerable position and a creation of consensus about the domination. For instance, in Mozambique formal education managed to impose biological notions of the human body associated with biomedical representations of health. Nevertheless Bourdieu's theorising shows a very easy consensus between the different actors about the acceptability of the (medical) practices imposed as legitimate by those with strong symbolic capital by means of symbolic violence. This for example may create the impression that the elites in Mozambique impose their representation of illness and medical paradigms and others will necessarily obey. Do they? What local forms of compliance and 'resistance' emerge in the public health field?

Overall Bourdieu's theorising is useful for analysing social positions and acceptance of medical practices in public health fields but some medical anthropologists have shown that it has some weakness too. They assert that Bourdieu does not consider the role of the body as a form of capital or resource in itself; that people and institutions use the body as a resource and commodity in therapeutic strategies (James *et al.* 1998; Shilling 1993). Another shortcoming of Bourdieu's conceptual framework (or its deployment at least) is related to identifying the 'field' as an autonomous space which does not take into account people's everyday social practices in relation to health but only those of professional and formal institutions (Meinert 2004). Based on her ethnography in Uganda, for example, Lotte Meinert argues that Bourdieu's concepts of capital directs more attention on individuals while in African contexts the family and kinship (and social relations) are far more relevant in shaping the social fabric of health. I therefore extend the scope

of the concepts of capital and public health field in this dissertation in order to capture other unities of analysis, different forms of capital and different settings.

It has been pointed out that power is not unidirectional or something that is externally forced on people, but involves people's subjectivity to subvert or comply with the forms of control imposed on them (Foucault 1979; 1980). Hence symbolic violence cannot solely explain the process by which, in the health field, those known to have skills to heal and those who transform these skills into influence and/or sources to control others can influence the resources of health and healing. Medical anthropology has made a distinction between power and authority in medicine. Here, power means the absolute ability of the therapists and medical apparatus to manipulate or control others, whilst in authority the control is exercised with the consent of the patients and assumes a legitimate manner (Janzen 2002). John Janzen asserts that in western industrial countries medical paradigms, institutions and therapists who represent them are given authority by the public because this "(...) is said to be based on scientific truth; is conducted by certified, licensed practitioners; it is protected by professional codes of ethics; and it is regulated by state laws, all of which are supported by the public or professional groups" (pp 221). But what makes people in Mozambique give authority to indigenous medicine to perform therapeutic procedures on them?

I draw on the notion of field to analyse therapeutic choice in Mozambique because in the public health field, the variety of 'healers', patients and institutions position themselves to deliver and use health services. The manoeuvring and use of health services will depend on the strengths of the various forms of capital held by people. Contrary to the systemic approaches that focus on availability, accessibility and organization of the 'medical system' as variables that determine the therapeutic choice, anthropologists working in political economy of health succeeded in demonstrating that different forms of symbolic capital (such as types of illness representation, forms of knowledge, and the types of social relations) play a significant role in deciding about the kind of therapy to provide and health service to use (see Meinert 2004; Samuelsen 2004).

2.4.2. Therapeutic landscapes and global politics of health/illness

Medical practices are shaped by relations of power at national and international levels. As discussed above the political economy of health is related to the ways in which different institutions and agencies manoeuvre their interests in order to influence the formation and maintenance of the therapeutic landscapes. However, this analysis has to be extended to the ways in which the health field interacts at the macro political level in the production and representation of health and illness.

Anthropological literature on political economy of health tends to overemphasize dependency theories when analysing relations of power between local therapeutic landscapes and global health fields. This theory, originated by political economists, focuses on the analysis of inequalities between developed and underdeveloped countries stressing the role of imperialism, colonialism, and capitalist penetration in health, sickness and poverty. The world system theory or dependence theory supports the idea that the development of the western developed countries leads inevitably to the underdevelopment of the developing countries since the rich countries will extract wealth and resources from the periphery resulting in its chronic underdevelopment. Then global social relations are evolutionary because they are determined by the expansion and intrusion into the periphery of capitalism and the world market (See Frank 1967, 1972; Wallerstein 1974). The term 'world system' is used to refer to global dependency and interpenetration, dominated by capitalist relations of production. Here, the focus is on the neglected effects of national and international asymmetric power relations that form health and sickness (See Doyal 1979; Janzen 1978a; Elling 1981).

The representation of illness examined from a dependency perspective conceives of a total penetration of the biomedical and monolithic capitalist health sector into the underdeveloped regions and the capitulation of indigenous healing practices. The world imperial health system is used as a synonym for a 'hegemonic' biomedical health system (See Elling 1981; Onoge 1975).

This way, contrary to the empirical conclusions of the approaches I have already discussed, dependence theory fails to explain the coexistence of biomedicine and indigenous forms of healing in the same health field, and even precludes the existence of the later as a form of knowledge. Similar to the systemic approach outlined above, that ignores the interdependence of the available medical traditions at local level in the shaping of health, sickness and healing, the world system theory excludes the interdependence between the local therapeutic landscapes and the global political scenario. The relations of power are unidirectional since it is the North that under develops the South with the capitalist system. Biomedicine, the approach asserts, is spread by the capitalist system into the market system, and it expands therapeutic functions through market mechanisms. Underdeveloped states purchase medicines, related commodities, technology and knowledge assistance from capitalist developed nations and start directing their capital and concentration toward clinical health. In this process they give up their medical resources and strategies that would suit their people (see Elling 1981; Morsy 1979). These assumptions were later criticised, *inter alia*, by some of its proponents for emphasizing economic determinism, overlooking social relations and neglecting cultural and historical specificity and social dynamics (see Morsy 1996).

The dependency theories also continued to focus the discourse on biomedicine when analysing international and national public health fields, reflecting a bias of superiority over indigenous medicine in Africa within the anthropological analysis. The discourse shows juxtaposition between binary categories such as developed vs. underdeveloped, western vs. non-western, North vs. South (previously called modern vs. traditional) and is criticised by the research on medical pluralism outlined above (Leslie 1980a; 1992). Another inadequacy of the world system oriented political economy of health in medical anthropology is the insistence in undermining the capacity of those within the local therapeutic landscapes to manage their health problems, and to 'resist' and influence 'the West' and biomedicine itself. The 'local' is cast as a passive agent and the

mutual influence between local and global is discarded. One of the consequences is that the capability and historiography of indigenous medicine is denied. Its history is still represented through derogative language, even by those who question class domination and health inequalities, and the way it represents health illness and therapy gets lost in the overemphasis of the analysis of the capitalist north dominating the south. An adequate proposal from Morsy (1996) suggests that when analysing relations of power between local and global health fields, we have to look at the mutual influence, focusing on the power, control, and defiance surrounding the representation of health, sickness and therapy, on culture in a historical located political economy and on micro and macro analysis.

2.4.3. The politics and geopolitics of efficacy

Questions of efficacy encompass both the way medical traditions produce the effective outcomes in the healing of sickness and misfortune, and how this interplays between national and global health interests and epistemologies that contest the legitimacy, positioning and meanings of health, sickness and healing. A political economy of health must thus examine how health delivery and efficacy of indigenous medicine interact with these structures of power and economy. The political agendas of international institutions have a strong influence in the design and appropriation of national health policies. They participate in the debates, manoeuvring and (mis)representing what medical practice heals or does not, and how, and where it is effective in the local health fields. For instance, efficacy is highly contentious and politicised by governments, WHO, and the World Bank. These institutions use and impose evidence-based reasoning to determine healthcare provision and construct treatments according to rankings of statistics, political agendas, and economic interest. The way the line of treatment of sickness is decided upon by the Ministry of Health (for example for malaria), is influenced by the power and lobbies of the pharmaceutical companies. The decision as to which tablets are efficacious may not only be

decided according to laboratory based evidences or intrinsic chemical capacities of medicines, but by symbolic violence.

Since the 1970s the World Health Organisation (WHO) has been engaged with a series of plans and strategies for promoting indigenous forms of medicine in the world and recommended that the state members take serious actions to implement them (See WHO 2000: AFRI/RC/50; WHO 2009: WHA 62.13)³¹. I am interested in understanding how Mozambican actors responded to these policies and how did they shape local representations of efficacy?

The World Bank structural adjustment programs and policies in Mozambique included health packages that forced the liberalisation of health services and enhanced the proliferation of the private health sector to counteract the socialist centralised health services. The proliferation of private clinics brought about new modes of engagement between doctors and patients in which biomedical healthcare providers began competing with each other and ceased sharing diagnoses and knowledge. How did these programs influence indigenous medicine practices?

In modern China, the efficacy of Tibetan medicine is not discerned through exclusively empirical statistical outcomes, instead it is produced by the demands of Tibetan doctors who navigate between the Chinese materialist ideology and Tibetan cultural secessionism. Efficacy or proof in Tibetan healthcare provision is not determined by epistemology alone, but also by the way this is reshaped to harmonise political and cultural ideologies (Adams 2002). The politics of efficacy is equally intrinsic to the dynamics of many other countries and plays an important role in the way local models of efficacy are represented in these health fields. In order to analyse this in Mozambique I will therefore look at how the models of efficacy of indigenous medicine are influenced by the demands of current political ideologies.

³¹ At <http://www.who.int/en/>

Geopolitics has been referred to as the implications of economics and geography on political systems which includes the relations between state and non-state actors pursuing individual as well as collective interests. These interests are focused, among other things, on resources, flows, identities and culture, territorial dominance and communications, which combine to create a geopolitical system. It includes the correlation between power and interests, strategic decision-making, and geographic space (Dodds 2007; Ó Tuathail 1996). I also introduce the notion of *geopolitics of efficacy* as a field of political economy of health by which the representation of sickness, and health/therapy delivery reflects current geographic and economic interests, as well as the social positioning of societies, cultures and States. A medical tradition or the efficacy of that tradition, is historically represented by the symbolic, politic or social prestige and power of those who use it, who strive to occupy positions and (re)produce their medical practices and resources within it. For example, it's the current geopolitically weak position of Mozambique contributes to the occlusion of the efficacy of its indigenous medicine. The dramatic economic and political rise of China as superpower in the 21st century has coincided with a new status and appreciation of efficacy in acupuncture medicine. This medicine has entered into the medical repertoire of many parts of the world in which insurance companies now accept it as a valid medicine to relieve pain and suffering of clients³². The social and economic influence of China in Mozambique is worth billions of US dollars and is reshaping social and historical relations, encompassing infrastructures and commodities on a massive scale (see Roque & Alden 2012). This has incited the creation of new meanings and authority of acupuncture and Chinese medicines.

The discourses on the efficacy of indigenous medicine reflect ideologies that may be challenged and legitimized in any historical moment. The models of efficacy, whether of indigenous medicine or biomedicine - symbolic, structural, persuasive, aesthetic or clinic – are shaped by a political

³² <https://www.acufinder.com/nsurance>

economy of health. It is the role of those viewing from a critical standpoint to offer a social and political interpretation of the meanings locked inside them (Nichter & Lock 2002). This dissertation will consider how both political and geopolitical factors foster or inhibit specific forms of production of medicine.

2.5. Conclusions

In this chapter I have outlined and critically discussed the different anthropological approaches used to analyse health, illness, and efficacy. I started by reviewing the notion of illness representation and efficacy presenting the disparate approaches undertaken by anthropologists and finished by proposing the integrative approach, which attempts to unite the current, yet one-sided perspectives. I have also presented the complexity underlying the definition of a health tradition, discussing the concept of health system, and have decided to use the concept of a 'medical landscape' as a framework for this dissertation. Moreover I have discussed issues related to the political economy of health and, based on contemporary discussions about social positionality and legitimisation of actors and health practices, I have placed the study into the debate around the health context, the relations of power between the local and global, and the politics of efficacy. From these discussions I summarise the key theoretical questions of the dissertation as follows:

- What are health, sickness and healing for those who use indigenous medicine? How can we inquire into illness and efficacy in a way that mediates with the way health services are delivered and contested in this context?
- How is the health delivery and choice of indigenous medicine made in relation to the therapeutic landscapes and the way in which it has been historically represented?
- How is illness and efficacy contested by different stakeholders in modern Mozambique, and how do social conditions and power relations produce, reproduce, and legitimise certain representations of health and efficacy in the health field?

CHAPTER III - METHODOLOGICAL CONSIDERATIONS

3.0. Introduction

In this chapter I present the methodological considerations underlying this study. This encompasses the research location, strategy and methods used to conduct the research and answer the research questions, the ethical consideration underpinning the study, as well as the limitations of the research process. I start by presenting the research setting, followed by the research strategy and methods, and finalise with the ethical considerations and limitations of the research.

3.1. Research Setting

I carried out this study in Mozambique, which is geographically divided into provinces, districts, and administrative posts, subdivided into *localidades*³³, *povoações*³⁴ and *povoados*³⁵. I located the research in Maputo City and Manhiça district (See map 2 in the next page). Maputo city³⁶ is the capital of the country and has a category of province. Along the dissertation I may refer to Mozambique, my research site, Maputo and Manhiça interchangeably.

Instead of focusing on geographic boundaries, the study focused on local experiences of health, sickness and therapy. The networks and practices of people in my research are located in different social and cultural groups. The *tinyanga* and their patients deliver and quest for therapy in the neighbourhood as well as in distant places within the region. Although my participant observation was based in Manhiça and Maputo, my research informants' pursuit of health and therapy went across these two areas.

³³ Localities

³⁴ Larger groups of people

³⁵ Small groups of people

³⁶ The first province after the Capital is also called Maputo and its capital is Matola.

Map 2. Map of the research location



People in Maputo City and Manhiça district are multilingual and speak Ronga, Changana and Portuguese. The forms of the first two languages are mutually intelligible. I conducted my ethnography in these three languages for which I have an excellent linguistic competence, including the command of orthography.

In both Maputo City and Manhiça districts Changana and Ronga are dominant languages and local medical ideologies are represented and constituted through these communicative resources.

The two locations were chosen due to their different social characteristics. Maputo is an urban area and Manhiça is a rural district. I needed to analyse illness representation and models of efficacy in both rural and urban social environments. The majority of people in Mozambique live in rural areas so it would be misleading to exclude this area from the research. On the other hand, Mozambique has a central system of governance, which concentrates the most important decision making processes in the capital city of Maputo. The provincial directorates are strictly subordinated to the central arenas of power in Maputo, and the documentation centres are in the capital as well. It is also in Maputo where the large, influential national media, NGO's, institutes, and documentation centres are located or have their central archives. Hence an understanding of therapeutic landscapes in two contrasting social settings would allow me to gather a more representative picture of the country.

I found Maputo and Manhiça adequate and manageable for my study because they are linked by the national highway number 1 (EN1), which, above all, facilitated my movements in the health field in terms of both transport and cost. People from this research setting participate in different common regional networks. For example, people from Manhiça attend university education in Maputo and some people from Maputo work in Manhiça. Maputo was to some extent built up by immigrants, which included people from Manhiça. These immigrants have left relatives and the extended family in rural areas. During the civil war, many refugees fled to the capital and

contributed to the rapid 'suburbanised' growth of Maputo City³⁷. When they returned home they maintained their residences and left their children in town for, *inter alia*, education.

3.2. Research strategy and methods

In order to collect the relevant data to respond to the research questions, I used a variety of research methods. As with most anthropologists, my research relied on participant observation. I also used a mixture of other qualitative methods of data collection which encompassed formal and informal interviews, documenting life histories, desk review, and participatory learning for action (PLA) (see Bernard 1995; Chambers 1992; Gardner & Lewis 1996; Kottak 2000).

I chose these methods to collect information about: (1) Diachronic and synchronic representations of indigenous medicine; (2) health and healing knowledge, practices and experiences of the people of Maputo and Manhica; (3) the delivery and choice of indigenous medicine, and (4) political and economic relations of power in Mozambique's health field.

I conducted desk review and observation in order to access information about the way local cultural agencies, social structures, and political processes represented and influenced the representation of illness and efficacy in the last decades. This information encompasses health discourses³⁸ and practices³⁹ in different communities of practice⁴⁰ and networks that shape the

³⁷ From the end of 1970s until 1992 Mozambique was devastated by a horrific civil war between FRELIMO government and RENAMO guerrilla movement.

³⁸ Discourse is here seen as a system of intellectual organization based on knowledge (Foucault 1970). According to Foucault a discourse is recognised by (1) a corpus of statements whose organization is regular and systematic. These statements encompass words and things (for example the environmental law discourse or the health discourse are recognised as such because they are regular and systematic); (2) the rules underlying its production; and (3) the rules that delimit its space in relation to other discourses.

³⁹ Variety of activities and actions about, for or referring to health, sickness and therapy.

⁴⁰ Community of practice defines a group of people who share knowledge and/or pursue same interests or a profession in a particular field. This group may designate people assembled in order to achieve a kind of knowledge associated to their field (Lave & Wenger 1991).

current health paradigm in Mozambique, and was collected at NGO's, The Ministry of Health (MISAU)⁴¹, The Ministry of Science and Technology (MCT)⁴², universities and institutes, research centres, district directorates of health, The National Aids Council (CNCS)⁴³, TV and Radio debates and news, news papers, and other relevant sources⁴⁴. I also used these methods for looking at global health programs and debates.

I used participant observation to gather local health and healing knowledge, medical practices and experiences, as well as health delivery and choice. In order to have access to these practices I participated in local and regional networks of the *tinyanga* and their patients. These networks also included people who were not necessarily seeking therapy at a particular moment. The assumption was that all social actors are patients of a particular health service since they, or their kin, potentially experience sickness. As a trained *nyamusoro* I had privileged and 'authorised' access to indigenous medical settings that included therapies and apprenticeship and training settings that are typically inaccessible to the unqualified. The *tinyanga* do not share some types of information and activities with those who do not belong to the same class and internal hierarchies due to power relations, secrecy and protection of intellectual property rights⁴⁵. In order to gain access to these therapeutic settings, learn and follow new healing practices and

⁴¹ Ministério da Saúde

⁴² Ministério da Ciência e Tecnologia

⁴³ Conselho Nacional de Combate ao HIV & SIDA

⁴⁴ I choose all these networks beyond academia to study the health paradigm following Jacobs & Mooney, whom, contrary to Kuhn (1970) who asserts that the paradigm is solely determined by the scientific community, argue that scientific knowledge is not only the achievement of organic scientific movements. Instead it is also formed by several others institutions and actors like the state planning centres, foundations, institutes, informal institutions, and (I add) 'healers', patients, the media, as well as ordinary people. My analysis of health discourses and practices takes this extended concept of paradigm and considers that knowledge is historically produced in socially, politically and culturally different and overlapping communities of practice.

⁴⁵ For example in the 'system' of indigenous medicine that I researched, medical knowledge is only transferable among the *tinyanga* and their students.

medicines, a trained *nyanga* usually agrees on a royalty (in form of *lovolo*) that can be paid to her/his host who transfers the knowledge. The *tinyanga* I worked with did not ask me for *lovolo* since some knew me from my activities in local public health campaigns, and others were part of the networks of *tinyanga* developed by the organisation where I work (PROMETRA⁴⁶). However, for the majority of indigenous health providers who contributed to this research, especially in Maputo, this was our first meeting. I integrated myself into the networks and managed to participate in a number of activities including therapeutic activities, healing practices and training activities. My engagement with the patients went beyond the working settings of indigenous medicine, into their homes, where their therapeutic choices were decided and their experience of pain and suffering took place. I attended indigenous health services in the patient's households. These home-based health services are first decided in a diagnosis or therapeutic encounter at the *tinyanga's* service place. I also engaged in daily activities, talked to different people, and visited different institutions and social events in Maputo and Manhica.

In order to access health and healing knowledge, medical practices and experiences, health delivery and choice, as well as health discourses and practices I also used formal interviews and documented life histories. With these methods I gathered information from the *tinyanga*, their patients and people I knew or contacted for the purpose of this research. People I knew included friends and people I work with or worked with in the past. Those I contacted are health planners, university lectures, program officers at NGO's, journalists and members of the general public.

My study needed knowledge about health, illness and healing as well as health delivery to construe local medical *lifeworlds* from the experience and perspective of the people represented in this study. For this reason I used participatory learning for action – PLA - (Chambers 1992; 1997) to work together with my research participants to gather local medical knowledge. The PLA

⁴⁶ PROMETRA – Promoção da Medicina Tradicional/ Promotion of Traditional Medicine. This NGO essentially works in the development of indigenous medicine and medical pluralism through health delivery using networks of *tinyanga*.

process involved a total of 63 *tinyanga*: 31 in Maputo (16 female and 15 male), and 32 in Manhiça (16 women and 16 men). Since most of them are illiterate and use Ronga and Changana languages for communication, we relied on these languages to work together and our participatory techniques and tools included: body mappings, sickness mappings, group discussions about illness/health experiences, visualizations with physical objects and group memory.

Afterwards I analysed the data collected using these different tools through a triangulation process (Becker 1986; Pelto & Pelto 1996). This data analysis process consists on confronting categories to reconcile and reveal the differences in perceptions emerging from the information provided by different data collection techniques. This was then analysed and interpreted in relation to the research objective and questions.

3.3. Ethical considerations

Research enterprises always have ethical implications associated to the conduct of the researchers themselves and to the academic institutions, states and development agencies that prescribe and dictate the ethical principles to be followed when currying out research. These ethical issues can be highly contentions within both the social and natural sciences since they are forms of positioning and, as such, reflect specific cultural as well as historical paradigms. However, there is a need to formulate the ethical principles involved in each specific research and strategies to overcome them in the field.

My research, since it is an anthropological inquiry, had to balance these ethical principles with local conceptions of ethics. It was undertaken using the 'ethical guidelines for Good Research Practice' of the Association of Social Anthropologists of the UK and Commonwealth⁴⁷.

In the following sections I outline the ethical considerations related to this research.

⁴⁷ Mozambique is a Commonwealth country

3.3.1. Disturbance of my research subjects

In relation to the disturbance of the research subjects, the ethics for the laboratory differs from those for the field. Subjects in the laboratory are highly controlled with a tiny degree of disturbance. However, anthropologists in the field have the potential to disturb the context they study because they want to observe a *natural* context whilst their presence paradoxically changes it. In order to minimise disturbance of my research participants I behaved in a manner that was culturally accepted locally and obeyed the universal accepted human rights of physical and emotional integrity and social privacy. I reconciled my wish to document my observations with the ethical requirement to be as unobtrusive as possible. The documentation process – interviewing, filming and observation - was scheduled in a way which took the availability and privacy of my research consultants into account. I also negotiated a reasonable time limit to perform the tasks without tiring them.

My research did not involve clinical trials to human beings.

3.3.2. Privacy of the research participants

The anonymity of my research participants was guaranteed in this research except where the publication of their identity was agreed, either because I asked my sources for authorisation to disclose their identity given that does not constitute a problem for their integrity or because they and their interventions are in the public legal domain.

It is commonly agreed that patient's records and the encounter between the sick and the health provider of indigenous medicine or biomedicine, have to be protected. My research followed the same path.

3.3.4. Informed Consent

I did not engage any patient in the research unless they agreed to do so and an informed consent was signed as a condition for them to join the study. The informed consent sheet provided the

participants with the reasons for the study, the benefits of their participation and how the data from this study would be used and preserved. I provided reading and translation services for those who could not read.

3.3.5. Recruitment to the study

All research participants joined this study voluntarily. Very sick or weak patients and children under 18 were not admitted to the research, except in participant observation where they could not be precluded.

3.3.6. Sponsorship

Sponsoring institutions can influence research by dictating what can and can't be written about. This research was undertaken under the Ford Foundation Fellowship Program, which did not interfere with the research. My scholarship contract with the program has a clause that guarantees no interference from the funding body or its associates, guarding my intellectual freedom and right to scientific production and publication.

I did not use my research to influence the results about the reality in order to benefit myself (beyond the doctoral study), any other person or institution that supported part of my study or that I am professionally associated to.

3.3.7. Bio-piracy and indigenous knowledge property rights

This study does not reveal the names of medicines used by the *tinyanga* or give any indication that may lead to their identification. I do not support bio-piracy⁴⁸ and disclose none of the indigenous knowledge either during my study, or in the dissertation, despite the fact that it is commonly accepted. There is lack of State legislation to protect indigenous knowledge property rights, however I followed my ethical position that supports this protection in the line of the

⁴⁸ The exploitation of local biodiversity resources by other nations or corporations (Fairhead and Leach 2003)

indigenous medicine strategies for protecting intellectual and knowledge property rights and the relevant international legislation in this area.

3.3.8. Indifference, positionality and ethics

During my study I sometimes encountered health rights issues associated with the unequal treatment of and derogatory language towards indigenous medicine and its practitioners. I was not indifferent to this unequal treatment between medical practices and people since these aspects underpin and reinforced the very social and historical misrepresentation that I am dealing with in this study. The deprecating language sometimes affected my emotions as a *nyamusoro*. How could I position myself when feeling personally insulted during an interview (because they were unaware I was a *nyanga*)? Or when fellow researchers and journalists insist on referring to me using terms such as *curandeiro* and *curandeirismo*? At the beginning it was not simple to deal with these issues according to the guidelines of the research methods books, but I later learned to gain control of my emotions.

3.4. Limitations of the study

3.4.1. Funding and timing restrictions

I initially planned to undertake my research in the province of Manica, in the centre of Mozambique, both in the capital Chimoio and the surrounding rural areas. At that time I wanted to conduct the research in Manica because, firstly, my professional aspiration as an anthropologist was to do ethnography in a different culture and, secondly, as a public health worker, it suited me to have knowledge of two different therapeutic contexts in Mozambique. I later discovered that this would not be possible as I could not afford the research there. After two months in Manica I also found out that over the 12 months I had allocated for fieldwork, I would not be able to develop the linguistic competence to grasp the local medical categories and idioms in the way I already knew them in the indigenous medicine that I practise.

3.4.2. Relationship between the research object and subject

This research has some limitations related to my relationship with my research object in two main dimensions. Firstly, although there are number of advantages to the *nyanga* researching indigenous medicine, for example in terms of access and understanding, there are also disadvantages when it comes to addressing some sensitive issues related to the relationship between power and authority of the *tinyanga* in health provision. Here the relationship between the researcher and the researched became blurred and I felt myself in the position of the research subject! Secondly, doing research at 'home' and within my own professional networks also turned out to be limiting. Social responsibilities and obligations, especially within my family, interfered with my research plan. Sometimes my professional duties and relationships also negatively influenced my research, when for example, there were ideological disagreements between some chains at the ministry of health and the networks of the *tinyanga* I belong to, which contributed to delaying the access to information and ethical authorisations.

CHAPTER IV - REPRESENTATION OF ILLNESS IN MOZAMBIQUE

4.0. Introduction

In this chapter I trace the historical, social, and epistemological foundations of the representations of health/illness and models of efficacy in Mozambique. I explore the different ways indigenous medicine has been represented in public health and in political, social and academic discourses. I demonstrate how approaches, perceived wisdoms and forms of power/knowledge concerning health, illness and therapy were constructed and represented socio-historically, and came into play in the public health field. The chapter is thus an account of the paradigms that underpin both the discourses on and the governmentality of sickness and public health interventions in Mozambique. I will argue that local debates about indigenous medicine are questionable because they have endured, *inter alia*, socio-historical, theoretical, epistemological, and methodological constraints.

The chapter is divided into four main parts. Firstly, I elaborate on the Portuguese colonial and cultural policy vis-à-vis indigenous medical practice. Secondly, I discuss health and sickness in the postcolonial state focusing on the role of the socialist revolution in the representation of indigenous medicine. Thirdly, I analyse the approaches and practices of the current neoliberal state toward indigenous medicine and examine how external impositions of the neoliberal capitalist model of structural adjustment and 'western' democratization reshaped discourses and representations of indigenous medicine. I will end the chapter by presenting alternative methodological and philosophical approaches to researching and framing illness/health.

4.1. Colonialism, cultural assimilation and indigenous medicine

In colonial Mozambique the relationship between the state and its subjects, including indigenous peoples and their cultural practices, was stratified. It was based on racial and social discrimination along with processes of cultural assimilation that were legislated in the 1929

*Estatuto de Indigenato*⁴⁹ (The Statute of Indigenous People). According to this colonial tool the population was divided into three main categories: the “colonial white/citizens” (*cidadãos*), the “assimilated people” (*assimilados*) and the “natives” (*indígenas*). The *cidadãos* were of high status, considered to have cultural superiority, and had full colonial citizenship including being afforded all the legal rights that were in force at the time in Portugal. The *assimilados*; second class in the hierarchy and servants of the regime, encompassed blacks, *mulatos*, mixed race people and Asians who had to abandon their cultural practices (the indigenous ones) through training and some formal education⁵⁰ (Santos 2006). Suffice it to say that:

“The figure of the *indígena* is opposed to that of the *assimilado*. The *assimilado* (...) was considered an African who was emancipated from his uses and customs and had acquired European cultural values. In the name of “tutelage”, the *indígenas* would be governed by customary law, while the *assimilado* would be governed by the civil public and private law of Portugal” (Macagno 2008: 223).

From the 1940s, Portugal declared Roman Catholicism as the official religion of the State⁵¹. In order to gain citizenship and get some citizen rights, the *assimilados* had to embrace Christianity and if possible Catholicism, behaving just as the Portuguese and abandoning all indigenous medicine practices and engagement with ancestral spirits (Harries 1994; Mondlane 1976[1969]; Ngoenha 2000). The *indígenas*, the lowest status, were subject to the colonial legislation but lived according to ‘indigenous’ laws and cultures. The social category of *indígenas* was racial and Portuguese colonialism institutionalised this and prescribed those who fitted into it, the black

⁴⁹ Decreto nº 16.473, de 6 de Fevereiro de 1929. Estatuto Político, Civil e Criminal dos Indígenas das colónias portuguesas de África.

⁵⁰ Portugal had two distinct educational systems in place, one for the *cidadãos* and another for *assimilados* (Ngoenha 2000; Mondlane 1976[1969]).

⁵¹ For an account of the consequences of this policy for the “Protestant” Churches in Mozambique see Ngoenha (2000); and Penvene (1994).

people, as the source of cheap and forced labour. The socio-cultural identities of local people were reinforced by this racial distinction between the *indígenas* and white colonisers, also called Europeans (Meneses 2010).

Although the implementation of the *Estatuto de indigenato* was more complex on the ground, its power in the construction of its 'indigenous subjects' cannot be ignored. This colonial form of governmentality created a social mindset predisposed to being assimilated in order to achieve social mobility and status, especially in those around the capital whose practices were subject to stigmatization and who had strong practical needs for modern services and facilities ensured by the colonial system.

Other colonial policies countered all indigenous cultural practices, including, importantly, the practice of indigenous medicine that was forbidden and prosecuted. In the heyday of colonial occupation, the government instructed all its governors to prohibit the activities of indigenous health providers and avoid their influence on the indigenous biomedical health staff (See Portaria nº 292, de 17/07/1911). The Portuguese penal code stipulated a penalty of two years imprisonment for those who would dare to practice medicine without an academic qualification (See Código penal Português artigo, 236º ponto 2. Maputo. Arquivo Histórico de Mozambique). Decree law nº 32.171 of the 29th July 1942, prescribes that the practice of medicine "(...) is only allowed to people legally qualified and registered in the medical association and who had also registered their professional qualification according to the law" (in Gulube 2003: 23)⁵². The colonial regime was creating a legal discourse around health that treated the available medical practices unequally. Biomedicine was legal and indigenous medicine illegal and its practice was prohibited and punished. It is worthwhile to note that the discrimination was also within the

⁵² See also articles nr. 2 and 5 of the ministerial diploma nº 78/92 of 10th of June.

practice of biomedicine itself since the *indigenas* had no access to university education in order to attain qualifications and be accredited at the medical association.

The colonial administration considered indigenous health practitioners and practices threatening to the modern Portuguese culture and against their 'civilised' world into which the native should be assimilated. This modern world encompassed biomedical practices and catholic religious practice. Indigenous practitioners were arrested and sentenced to jail imprisonment or forced labour. These discriminatory practices revealed that the *indigenas* in fact had no civil rights because paradoxally they were neither "citizens" nor "assimilated people" but savages. They were forced to take poorly or unpaid jobs, had limited, segregated education, and were subjected to physical violence, prosecution and deportation to penal colonies, plantations, and construction of infrastructures (see Mondlane 1976[1969]; Penvenne 1994).

Obdias Chilaule and Mariana Dzimba, *vanyamusoro*⁵³ from Manhiça and Maputo respectively, like many other elderly *tinyanga* who have been practicing indigenous medicine since colonial times, reported that they were arrested, beaten and sent to jail for practicing indigenous spirit mediumship. Obdias said that he was arrested by the local administration in 1952 when he was performing this therapeutic practice to a family in Bilene district. He was picked up coming from his home in Manhiça (Calanga), accused of practicing *curandeirismo* and sentenced to forced labour in Boane district. My grandfather was also arrested by the *sipaios*⁵⁴ in the first quarter of the 1940s, tortured and sent to Manhiça where he was sentenced to twelve months imprisonment for being found conducting diagnosis (the so called 'divination' in anthropological literature). There is a mass of colonial documentation supporting these narratives, full of testimonies of

⁵³ *Vanyamusoro* is plural of *nyamusoro* which is a type of indigenous health provider fully described in chapter V.

⁵⁴ *Cipaios* (sepoy) were Mozambican black soldiers and rural police officers who operated under the command of a Portuguese official.

similar prosecution of the *tinyanga*, especially mediums, by the colonial regime (See, for example, Honwana 2002: 120-128).

The legal discourse and practice developed and defined arenas to be under state control, transforming the law into a mechanism of social differentiation of those within them (Meneses 2010). There was, nevertheless, a big gap between policy and practice since the population continued to practice indigenous therapies:

“Who would live without performing a *mhamba*⁵⁵? We would be abandoning our ancestors and bring *ntima*⁵⁶ into our *svixiviri*⁵⁷ and *jangu*⁵⁸ (...). The Portuguese where completely wrong in their plans to eliminate indigenous medicine (...) because even the *Chefe to Posto* (Chief of the Administrative Post), who previously sent his people to arrest me, used to come to me for a consultation (...) They also had problems with their ancestors (...)” - (*Nyanga Ntshukana* - Manhica).

That colonial personnel themselves sought the therapy of indigenous medicine is documented in many parts of the country⁵⁹. It appears that colonial officials were being acculturated to local medical practices and worldviews. Some began knowing and engaging with their ancestors and reshaping their representation of illness and personhood. This shows that colonial policies and legal legislation were culturally disembodied from, and had contradicting nuances in the context in which they were applied.

⁵⁵ A ritual of social reintegration and communication with the ancestors

⁵⁶ Type of indigenous sickness (described in chapter V).

⁵⁷ Indigenous health category that encompass both the person's spirit and the identity (see chapter V).

⁵⁸ Family

⁵⁹ 13 elderly *tinyanga* among the 63 I worked with in the PLA told their encounters with white personal in their health service provision seeking for diagnosis and therapy. Some life histories show ties between the 'natives' (black) and Portuguese (whites). For example, as *comadres* and *afilhados*.

Within the different legal strategies used by the colonial regime to deal with health issues and the control of human subjects, illness was seen as physical and biomedical. The colonial administration used terms like *curandeirismo* and *feitçaria* (witchcraft) to label indigenous health practices and *curandeiros/feiticeiros* (witches; witchdoctors) to describe the practitioners⁶⁰. But Portugal was a weak state and did not actually have the economic capacity to control the colonies. In Mozambique the administrative control of the country, especially the north and centre, relied on foreign companies called *companhias majestáticas*. Portugal transferred full administrative obligations to these concessionary territorial companies along with the right to implement the discriminatory laws. Here, indigenous medicine was not only resilient because of its cultural acceptance, but continued to be practiced and delivered as health services in many areas of the country because neither the companies nor the state had effective administrative control of the territory.

Biomedical healthcare, academic research, and the catholic religion and evangelisation were key to the modernization and occupation by the colonial regime. Colonialism targeted sovereignty over the territory; the assimilation of local religions into Christianity, and the assimilation of indigenous knowledge by the means of scientific knowledge. In this process biomedical health services tacitly connived with the Catholic Church and missionaries and colonial academics.

For example, colonial officials carried out several studies in order to understand the *indígenas* and aid the colonial administration. Rita-Ferreira (1960, 1966, 1967/68); Ferraz de Freitas (1957); etc⁶¹ were amongst the colonial officials who undertook studies to respond to colonial administrative concerns. Their studies informed colonial policies and reproduced a way of seeing the practises of indigenous medicine. They portrayed these as obscurantism, irrational and as a

⁶⁰ See Decree law nº 23.229 from 15/11/1933, article 9º, on Main Legislation Applicable to Indigenous from the Mozambique Province. Lourenço Marques: Imprensa Nacional – Mozambique. 1960.

⁶¹ See Kirchner (1990), collection of texts on indigenous medicine in Mozambique.

threat to colonial 'modern' medical practices. Indigenous healing is represented in these studies as a set of occult practices that should be regarded with suspicion since they were irreconcilable with scientific scrutiny, and were jeopardising the indigenous people's assimilation of scientific thinking.

Other studies were conducted by missionaries, whose aim was to understand and evangelise indigenous people (see Junod, H. 1996 [1912]; Earthy 1933). All these studies regarded indigenous medical practices, as primitive beliefs, obscurantism⁶² and contrary not only to biomedicine but also to Christian and catholic experiences. The natives should be saved from these traditional primitive beliefs and practices through the 'Word of God' and biomedicine.

These colonial academics and missionaries betrayed their bias about the reality they were studying using labels that tell us more about them than its proposed referents.

4.2. Health and sickness in the postcolonial State

4.2.1. The Socialist revolution and indigenous medicine

Mozambique became independent from Portuguese domination in 1975 after a war for liberation that lasted 10 years – from 1964 to 1974 – ending with the Lusaka agreement in Zambia. The revolutionaries in Mozambique were pursuing independence conceived of as political self-determination. Independence would bring Mozambique new forms of interaction with international institutions and states. Its politicians also reflected on philosophical issues concerning education, health and administration. They considered, for example that indigenous education was unable to respond to the postcolonial administration. Ngoenha (2000) mentions that for these elites the independent Mozambique could not be built with indigenous education because it was unlikely to solve the sort of modern administrative problems at hand. Severino Ngoenha gives examples of

⁶² The capacity to influence other peoples luck, or to harm them (Junod 1996 [1912]).

Kwame Nkrumah, the president of the first independent country in Africa (Ghana) and other African thinkers, for whom the independences of the African postcolonial States should be administrated with 'western' modern values.

Anderson (1991 [1983]) argues that, in African countries, the nation state was built by local educated elites who were not akin to the rest of the population due to their colonially inherited linguistic, cultural, administrative and educational abilities. These elites acquired the socialist political views that in the 1950s-1970s were supporting the struggles for independences around the world but they brought colonial social and professional practices into the new postcolonial state. In Mozambique the revolution was led by such people, who had received a colonial education but who also had roots in local 'traditional' practices; 'hybrids' of colonial inculcated cultural practices and indigenous values. They portrayed many colonial cultural and social representations of governmentality. They did not abolish the colonial discriminatory legislation on public health, and the discriminatory articles of the colonial penal code were retained in the new legislation.

After independence, the socialist government led by FRELIMO⁶³ adopted a socialist Marxist and Leninist policy. The version of the regime strongly emphasised scientific socialism and materialism as the State philosophy and was entirely opposed to religious expressions, including representations of indigenous medical practices. The regime envisioned the construction of a socialist Marxist and secular Nation State where traditional power structures, including the *tinyanga*, had no role and were banned (Honwana 2002; Santos 2006, West 2005).

The cold war opposed the capitalist and socialist blocks in the world and Mozambique was associated to the latter, led by the former Soviet Union. The Southern African enemies of the

⁶³ Frente de Libertação de Moçambique/ Mozambique Liberation Front.

socialist Mozambican regime at the time; the apartheid regimes of Southern Rhodesia⁶⁴ and South Africa, incited the institutionalisation of local forms of security and control of the country. The socialist regime instituted, for example, the *grupos de vigilância popular* (popular vigilante groups) and popular militias to deal with security with strict coordination and command by the FRELIMO (party). These groups were used to persecute the *tinyanga* accross the country.

Biomedicine and the imagined biomedical healthcare 'system', which were part of the modern world order and supported by regulatory institutions such as the World Health Organization (WHO) and development agencies, were used by the state party FRELIMO as instruments of governance. The governmentality of biomedicine was more easily accepted and reified by the elite in the postcolonial and deprived Mozambique (as in many other developing countries) not only because it was inherited from the previous era but because it had political support worldwide. It was also the only type of knowledge and skills public bureaucrats had to run the state health services. Colonial education and health delivery services did not train public bureaucrats in indigenous medicine because they outlawed and downgraded it within the state system.

The rulers changed, the discrimination remained. As with the colonial regime, the new State had a troubled relationship with all indigenous structures including indigenous medicine. The political paradigm progressed from colonial positivism to socialist scientific materialism, and both used biomedical philosophical and methodological approaches to health and illness. The latter appropriated and instrumentalised both biomedical and Marxist knowledge for political ends. The socialist regime considered indigenous medicine as *feitiçaria* (witchcraft) and *superstição* (superstition), and not as a medical practice that could be subject to planning or scientific

⁶⁴ Zimbabwe

inquiring. As the colonial and postcolonial language, the Portuguese language has incorporated derogatory expressions to classify (and stigmatise) this social reality.

The Mozambican revolution changed the dominant elites, who controlled the modes and means of production, but did not eliminate the relations of knowledge and power in the health field; it just changed the dynamics of these relations of power by replacing the coloniser with the product of its assimilation policies which, in the end, was even more repressive in relation to indigenous knowledge.⁶⁵

4.2.1.1. Patients, *tinyanga* and the revolution

The *tinyanga* were persecuted all over the country by the army and mainly popular militias and still people continued to use them to address their health problems. In trying to state the reason for such vitality of indigenous medicine I am drawn to Meneses's (2000) argument that the so called indigenous medical traditions are produced in and by all sectors of social life redefining the concept of health and illness beyond the categories of unhappiness and physical impairment into symbolic, cognitive and institutional aspects that are intrinsic to and motors of the societies in which they are practised. Luisa Meneses goes on to argue that local explanations of health and illness directly portray the norms and representations that underpin local socio-cultural structures, which is why indigenous health institutions are simultaneously religious, political and therapeutic institutions.

Social change characterized by urbanisation, migrations, systemic education and state bureaucracy did not produce people completely disconnected from their traditional roots but:

“People committed to the previous (social) order and internal tensions, contradictions and discontent due to inequalities generated by situations such as unemployment, lack of democracy.

⁶⁵ For similar accounts in Guinea Conakry see Fairhead and Leach (2000).

These modern agents do not, therefore, mean rupture with the past but the crystallisation of the necessary traditional models of reference and belonging. This subtle dialectics between modernity and tradition is what animates and develops indigenous medicine (...) far from generating an aversion to progress, they feed themselves with this eminently problematic modernity and take possession of its multiple characteristics and metamorphoses in order to give them meaning and signs (...)” – Meneses (2000:28.[free translation]).

FRELIMO’s instructions to prohibit the practice of indigenous medicine were in some cases used to resolve personal rivalries among members of the community. For example, in Maputo, a chief of the block (*Quarteirão*)⁶⁶ or 10 houses (*10 casas*) could express rivalries with the families of *tinyanga* accusing them of practicing *bruxaria* (witchcraft) because the latter were often prominent and well-off (in incomes and assets). *Tinyanga* earned well from their practice. This influenced the kind of persecution some members of the community inflicted on the *tinyanga*’s families and the reasons why indigenous medicine was sought out. The *tinyanga* were selling private health services in a socialist State where private trade was forbidden or only authorized in special circumstances and under state control, but never in the area of health provision. They were acting as if they were in a free market creating social differences. Moreover, their incomes and assets were likely to be drawn on by local chiefs to reclaim their positions.

Most of the *tinyanga* were practising indigenous medicine hidden from the public eye, although not from the knowledge of the people, because patients and ‘healers’ were part of the same community of practices and networks. The revolution could not manage to eliminate the *tinyanga* but aimed to force them to abandon the therapeutic practice as part of the philosophy of the creation of the *Homem Novo/New Men* proclaimed by the revolution. For the Mozambican revolution the *New Man* was represented as a break with the values of the ‘colonial culture’,

⁶⁶ Maputo was divided in *Distritos urbanos* (urban districts), these in *Bairros*, followed by *Círculos* and *Quarteirões*, and then these by *10 casas* (10 houses). Each of the level had its own chief headed by the party cell and secretary.

'bourgeoisie culture', and the 'traditional culture' (See Machel 1970; Vieira 1978). Paradoxically, several state workers and leaders who were supposed to prosecute indigenous medicine had relatives practicing it, were indigenous healers themselves and/or had to use the therapeutic practices of indigenous medicine⁶⁷. Unsurprisingly, this revolutionary idea of eliminating indigenous practices and embrace the creation of the new socialist country, in which citizens would be emancipated from "tribalist", 'obscurantist', 'feudal' and 'colonialist' practices and have sense of solidarity and patriotism, was never fully achieved (Macagno 2008).

The hostility against the *tinyanga* took different forms across the country. In Maputo the prosecution was much stronger so the *tinyanga* adopted different strategies to continue practising, such as performing many therapies at night, so less visible from the public scrutiny. The provision of some indigenous therapies at night-time became a normal procedure and this practice continues today. In Manhiça the same strategy was adopted but local kinship and neighbourhood relationships were tighter and community interdependence did not allow the kind of hostility observed in Maputo. Here different social and power relations configured and influenced the ways and degree to which people were practising indigenous medicine. For example, in order to deal with its weak administrative capacity to control the country, and with the need to eliminate traditional authority, the revolution replaced local power structures with party cells and *grupos dinamizadores* (dynamising groups), and transformed chieftaincies into *círculos* with secretaries. However, in Maluana, as in many other parts of Manhiça, the traditional structures were just superseded by people from the same family, which maintained the power within the same kinship structures. In *Nsihanine* and *Wusiwanine* in Calanga, Manhiça, for example, the traditional leaders were replaced by their brothers who became the local secretary of the party.

⁶⁷ See West (2005) for similar examples in Cabo Delgado Province, north of Mozambique.

Whilst biomedicine was often associated with modernisation and technology, this was only in urban areas. When Mozambique gained its independence from Portugal, it was short of human and financial resources and consequently its government and administrative structures were weak. Added to this, the civil war between the rebel movement RENAMO and FRELIMO's government destroyed the little infrastructure that was inherited from the colonial era. It gradually cut all communications and administrative services in the majority of the 128 districts, and the state could not deliver biomedical health services in rural areas. Even if it had done so, this would hardly have forced people to abandon the use of indigenous medicine in favour of biomedicine given that indigenous medicine was familiar and drew on their representations of health and illness and notion of personhood whilst biomedicine was not. Other factors came to reinforce people's attachment to indigenous practices and medicine. RENAMO's ideology was opposed to the FRELIMO government's policy of the 'socialisation' of the country, and in the theatre of war, it supported traditional authorities and indigenous healing within its strongholds, which were largely in rural areas. Mozambican peasants sustained their support of RENAMO's guerrilla, either because they wanted to preserve the endangered 'traditional' culture (Geffray 1991), and restore dignity and authority to the 'traditional' authorities (O'Laughlin 1992), or because the war reshaped local identities and called upon the youth to gain new fields of power vis-à-vis the traditional inter-generational relations dominated by the elderly (Dinerman 1994). Nichter & Lock (2002) argue that the commonly held belief that scientific materialism (just as with colonialism and its modernisation and positivism) would fully emerge and biomedicine would oust 'tradition' in medical pluralistic contexts has fallen apart, and has so far been challenged worldwide. I support this argument.

4.2.1.1.1. *Whose independence is this?: Negotiating for the end of repression*

The late Dzimba, in the presence of another elderly *nyanga* Langa, both co-founders of the Mozambican Association of Traditional Medicine (AMETRAMO), told me that:

“(...) the repression was so strong and the secretaries of the party in Maputo were so hostile that we could no longer practise (...) We thought something was wrong (...) whose independence is this?, why say we are independent while we were not free to practise indigenous medicine?” - Dzimba⁶⁸.

Langa interceded: *“Namanje amasungulela ya FRELIMO ave yawuntunga”*/ “In fact the early FRELIMO government was composed of crazy people”.

“We decided to go to the top, to complain to the chiefs (...) we went to see Samora Michel’s⁶⁹ father in Chilembene (Gaza province) (...) he knew us (...) and we explained our preoccupation to him ! He then instructed us to return in a month’s time because Samora would be there visiting him (...)” – Dzimba⁷⁰.

Following the instructions of Samora’s father they went back to Chilembene the day before Samora’s arrival, and at the next day, Dzimba said, Samora was accompanied by his Vice-president Marcelino dos Santos and his Minister of foreign affairs Joanquim Chissano.

“We were shaking, completely afraid (...) Mazanga and (the late) Mathe (co-founders of AMETRAMO) said to me today we will be sent straight to jail (...). Then we were called in and asked to present the problem (...) we said to Comrade President that when we became independent we thought we would finally be free from persecution but that did not happen (...) our ancestors (vakokwani) practiced indigenous medicine and our fathers raised us communicating with the ancestors (navaphahla), today we are asked to abandon indigenous

⁶⁸ Interviewed in 2005 for PROMETRA’s indigenous medicine history project

⁶⁹ The first president of independent Mozambique and leader of the Mozambique’s socialist revolution

healing (wunyanga) (...) we did not want to become tinyanga but were chosen by the ancestors (...) then where will we go comrade president?" – Dzimba.

Dzimba said that Samora Machel listened to him quietly and very attentively. Then he said to them that they did not tell the party to eliminate or abuse the *tinyanga* but to ask them to calm down a bit (whatever this means). He instructed them to go out and while they were on their way out he said to Chissano: Chissano, *write the following letter to Hélder Martins* (first minister of health of the postcolonial State). Afterwards they were called to be given the letter. According to Dzimba and Langa, Samora instructed them: *"Take this letter to the Minister of Health and tell him that it is me who sent you over"*.

Nobody was able to tell me exactly what was written in that letter but, taking into account the actions undertaken by the Minister of Health and (according to the sources that I have been quoting) his irritation when he read it, it can be inferred that the leaders of the government (Samora Machel, Marcelino dos Santos and Joaquim Chissano) had given orders to the Ministry of Health to work with indigenous medicine, but how and to what degree is difficult to assess⁷¹.

Honwana (2002) reports on a meeting organised by FRELIMO through Hélder Martins and held in Maputo at some point between 1978–1981 in order to solve internal rivalries within AMETRAMO between the members, "(...) in the meeting the Minister promised to help to create one common association for all *tinyanga*" (p145). My informants said that this occurred immediately after the Chilembene letter. The oral sources do not recall the exact dates, but the letter must have been written in 1977.⁷² The Ministry of Health created the

⁷¹ I tried to trace the mentioned historical letter to Hélder Martins but was told it was destroyed in the process.

⁷² There is an historical inaccuracy in dates but the events are precise.

Cabinet for research of medicinal plants and traditional medicine (GEPMMT⁷³). The aim of this cabinet was to describe plants and therapeutic procedures in selected pathologies used by the *tinyanga* and to integrate them into the ONHS⁷⁴. “The project of the Ministry of Health was to restore the knowledge of indigenous plants but not the holders of this knowledge due to their *obscurantist practices* (Martins 2000, quoted in Meneses 2000).⁷⁵

Nguenha (2000), argues that the ‘negritude thinking’ prevalent among revolutionary regimes wished to preserve indigenous values, but as folklore, because they did not conceive them to be useful for the postcolonial society. This idea, however, is difficult to implement in practice, when placed within interactions of power, objectification and subjectification between the State and the *tinyanga* and sickness behaviour. The socialist system persecuted indigenous medicine and tried to discard it, but did not succeed, and it seems clear that the involvement or position of the political leaders was at odds with this persecution. Whilst the official ideology shows continuities from the colonial period to the revolutionary era in relation to the hostile treatment of indigenous medicine, the social practice demonstrates discontinuities characterised by designs and redesigns of the representation of and the relationship with indigenous medicine on the part of the leaders and State. Although some colonial administrators and officials used indigenous health practices, overall the political stance in relation to indigenous medicine was firmly discriminatory. However the socialist system and its leaders faced ‘resistance’ and defiance from the *tinyanga* and this opposition was reproduced by their own identities in relation to indigenous practices. It was also complex for them to oppose *tinyanga* without jeopardising the social and public support that they certainly wanted to preserve. Nguenha’s conclusion cannot be generalised across all African countries. It fails to analyse local historical and social dynamics in which the revolution

⁷³ Gabinete de Estudos de Plantas Medicinais e Medicina Tradicional.

⁷⁴ Official National Health Service

⁷⁵ See similar policies implemented during the African Nationalist revolution under Sekou Toure in Guinea-Conakry (Fairhead and Leach 2003).

took place in Mozambique and does not consider the accountability of these leaders to their people and within their social networks.

Alcinda Honwana, who reported on that celebrated meeting above, argues that there was a contradiction in FRELIMO's policy towards indigenous medicine since they were battling it on the one hand, while on the other, were dealing with it pragmatically because they were conscious of the "importance and power of the *tinyanga*, although officially and publicly they rejected and downplayed it" (p146). This representation in relation to policy and official positioning of the "new socialist society" created a schizophrenic society that embodied contradictory identities. People lived in two social worlds, one 'authorized' by the official discourse, and the other presumed to be inexistent, yet in force in social practices, and even acknowledged and supported by the political leaders. People relied on indigenous medicine but could not talk about it publically or promote it. Consequently, throughout the country the *tinyanga* were visited and worked at night.

4.3. Neoliberal State and the plural health field

4.3.1. Indigenous medicine in the neoliberal State

The civil war that involved the rebel movement RENAMO and FRELIMO's government forces intensified in the 80s. Many people were killed and there was a social break and an economic collapse that contributed to a greater discontentment of the people and a reduced government support (Geffray 1991; Honwana 2002, Macagno 2008). The government was also stretched to its limits with the war and economic breakdown. Moreover, according to Lorenzo Macagno the civil war also contributed to the political polarization of the debates around traditional authorities, which afterwards stimulated the process through which discourses about traditional values became idioms for claiming an alternative modernity in the country.

The period 1985-1994 was characterised by the end of the revolutionary system and an external imposition of the neoliberal capitalist model of structural adjustment and 'western'

democratization. From the 1994 to today, Mozambique has been constructing a neoliberal democratic state (Santos 2006).⁷⁶ Changes included the revision of the constitution; the introduction of the multiparty system; freedom of expression and a deregulated market economy in the country. The typically indigenous practices and institutions that were persecuted under colonialism and socialism would now be promoted under this umbrella. Two main legislations symbolize the change of the policy of the state in relation to indigenous knowledge: BR nº 15, I Série de 14 de Abril de 2004 - The Policy of Traditional Medicine, and Decree Nr. 15/2000 - Creation of local Community Authority.

The elites who liberated the country and governed during the socialist revolution were the same ones ruling in the neoliberal era and had acquired colonial and revolutionary cultures (Santos 2006). For example, Alberto Chissano, the former minister of foreign affairs of the socialist period (1975 – 1986) became the President of the country in 1986 with the tragic death of Samora Machel in a plane accident. The FRELIMO structure was almost the same and included Marcelino dos Santos and other main ideologists of the regime in the Central committee and Political commission of the party. These people still have political control of the state and the health sector. They introduced new cultures of governmentality characterised by acceptance and tolerance of medical pluralism in the country. In state policy and discourse, indigenous medicine was no longer officially cast as obscurantism but as 'traditional medicine', and the governmentality of health would be (the policy level envisioned) through both biomedical and indigenous medical bodies. The new modernity of public health would encompass the promotion of indigenous medicine in the health sector. The 2007 National Health Policy and the 2004 Policy on Traditional Medicine reflect this reconfiguration of the health discourses and representations of health.

⁷⁶ In which the private sector, liberalized trade, and open markets are believed to promote economic growth and globalisation leading to social development.

The 2007 National health policy is organised in *general objectives* and *urgent general objectives* within main umbrella areas. Indigenous medicine is within the area of *forms of organisation of healthcare* delivery and here the policy is interested in “*promoting the development of indigenous medicine practices in scientific ways and inciting collaboration with the practitioners of indigenous medicine*”. Collaboration should focus on the mobilisation of the *tinyanga* to support health campaigns on health promotion and mental health. The policy is also interested in converting the *empirical knowledge* of the *tinyanga* into *scientific knowledge*. It also mentions the implementation of campaigns to training the *tinyanga* in *bio-safety*. The policy is also interested in the valorisation of indigenous medicine and in the regulation, normalisation, and supervision of their health delivery. The output here is that the *tinyanga* will be controlled by the Ministry of Health but without recognition of their professional status and knowledge, which is considered to be in an inferior position since it is not *scientific knowledge*.

The policy brings modern nuances in which the discourse implies that the *tinyanga* are an important part of the health field and can help in the capitalisation of health interventions because they have cultural competence, especially in certain issues such as mental illness. It also states the intention of valorising and promoting indigenous medicine within the new context. This promotion comes with the discourse of scientific knowledge, since the control of the health sector in Mozambique is in the hands of biomedical, biological and chemistry sciences, and so inevitably reflects their method and epistemology.

Between 2000 and 2003 the Ministry of Health transformed the GEPMMT into a department called Department of Medicinal Plants and Traditional Medicine (DPMMT). The DPMMT, inspired by World Health Organization (WHO) resolutions and recommendations⁷⁷, took a more significant

⁷⁷ WHO recommends the promotion of indigenous medicine into public healthcare services of the member states. The regional and world policy makers at WHO argue that ‘Traditional Healers’ play an increasing role in primary healthcare (OMS 2001).

step in the materialisation of the intentions stated, by drafting a policy for indigenous medicine within the National Health Policy, which was approved by the Mozambique's government in 2004. The policy for indigenous medicine, it was argued, would primarily address the healthcare access and development of the majority of the population who rely only on this medicine. It intended "to make an appropriate use of traditional medicine and integrate it into the national health system, in order to contribute to the objective of health for everyone, declared by the World Health Organisation (WHO) at the Alma Ata conference⁷⁸ and accepted by member countries" (Governo de Moçambique. BR nº 15, I Série de 14 de Abril de 2004). Although the policy focuses essentially on promoting indigenous medicine, it also refers to Asian medical "systems" which are called 'alternative medicine'. The policy distinguishes between traditional medicine (indigenous medicine), conventional medicine (biomedicine), and alternative medicine (Asian medical systems: mainly South Asian Ayurveda and Chinese acupuncture). But what is conventional or alternative? To whom? And where?

This policy, however, was not disseminated to different stakeholders nor was it implemented, the practitioners of indigenous medicine never being formally prepared to fulfil their new functions in health provision. The proponents of indigenous medicine occasionally undertook advocacy and public interventions, mainly during the celebration of the 'African day of traditional medicine' which is commemorated every year on the 31st of August. But even on this day, politicians made public interventions that did not meet the expectations of the new policy. They portray very poor representations concerning indigenous medicine. For instance the vice-Minister of the 2010 – 2014 administration, on the celebration of the African day of traditional medicine delivered the following speech:

⁷⁸ The Alma Ata resolution of 1978 was declared in ex-USSR by the World Health Organization member state. (see <http://healthydocuments.org/public/doc9.html>)

“We have decided to constitute the Institute of Traditional Medicine in order to identify harmful practices and turn them into positive practices. For example, the belief that newborn babies have to take medicine for the moon⁷⁹ is wrong and harmful because babies should only take the mother’s milk until they are three months old, and this disease does not exist at all (...) It derives from bad practices that we are sure we will eliminate with this institute because they are resistant to good practices of the hospital (...)” – Nazira Abdul, 31ST of August 2010, *Telejornal*, Mozambique Television (TVM).

This statement is not what one would expect from this setting and the aims of the African day of traditional medicine; the 31st of August which was created in order to promote indigenous medicine. As an analogy, one would not be expected to talk about doctors who trade kidneys, or police officers who act like bandits, on their promotional day. People do not deliver similar speeches when addressing other “professions” because they are legitimate, whilst indigenous healing is not. But this speech shows no conformity to the policy as a whole or to its basics tenets. It reveals instead that ‘traditional medicine’ has been stigmatised and the speech just reinforces the stigma. The statement made on that day also downplays the efforts that the *tinyanga* have been making to deliver their services, even though were deprived of support and faced different forms of persecution.

The research and academic institutions, local State and private universities and institutes that have health sciences in their curriculums have continued teaching only biomedical courses with no indigenous health content. They did not envision introducing topics from indigenous medicine into their curricula. All NGO’s and Foundations working in public health that I have encountered

⁷⁹ Known as *murhi wa wheti* / medicine for (the prevention of) *mavabzi ya wheti* - epilepsy. It is given to children to heal an agent known as *nyokana* which ‘lives’ in harmony with the moon (*wheti*). When the moon appears some children are more affected than others, until they become teenagers. Some children develop *mavabzi ya wheti* while others do not.

were bracketing indigenous medicine in their programs and actions. It is worthwhile to discuss the way, for example, some of the academics from local universities reflect on indigenous medicine.

Silvério Ronguane⁸⁰ focuses on the scholarly knowledge of biomedicine, which he claims has 'won'. But local statistics show that 54% of Mozambicans are illiterate and the contextual reality about literacy is that most of the educated are concentrated in urban areas and in particular in the capital Maputo. Rural areas have 66% illiteracy, and the urban areas have 34%. The rate of illiteracy in Manhiça is 78% whilst in Maputo city it is 15%. Mozambique is also a multilingual country where Portuguese may be the official language and the language of formal education but is only spoken by 24 % of Mozambicans with the remaining majority speaking Bantu languages. Most Mozambicans gain their communicative competence to speak Portuguese in schools. Then there is a correlation between knowledge of Portuguese and literacy. This formal education is typically located in the capital and other cities, mostly in the south of the country. Its knowledge (when it is not teaching religious studies) has the positivist foundations of the natural sciences, and encompasses the biological notions of human body, health, and sickness claimed by biomedicine. So it is reasonable to ask, how can the discourse of biomedicine 'win' and be hegemonic in this context, as he claims? Ronguane's thinking overlooks the ontology of indigenous health practice that is used in 'syncretism' with biomedicine and by the majority of the population.

Following Gramsci, Neo-Marxists elaborating on illness representation, associate common sense with 'hegemony'. They define hegemony as "the permeation throughout society of a system of values, attitudes, and so forth that supports the status quo and becomes internalized to such an extent that it seems like common sense" (Pool & Geissler 2005:28). In suggesting that biomedicine has 'won', Ronguane is essentially suggesting that it is hegemonic, which is not the case in Mozambique. The system of values, attitudes, and paradigm of biomedicine has not

⁸⁰ Mozambican philosopher and lecturer.

permeated into the whole society and neither has it taken control of the places where they are in use. Instead they are in vogue in some circuits and where they exist, they share the same therapeutic landscapes as indigenous medicine.

The notion of hegemony is misleading in this case, since it assumes horizontal power of one social class subjugating another. It has a Marxist view of one class projecting power over the dominated class. This view ignores that power is more than a mere political domination or something that is imposed on people from outside them. It disregards how relations of power are both intrinsic to society and involve people's subjectivity to subvert political power (Foucault 1979; Foucault 1980).

It is also said that the knowledge that *tinyanga* have about medicines is generalised; that it is shared with the population, and "the practitioners of traditional medicine were entrusted to select and prepare them in the most appropriate way" (Palha de Sousa⁸¹ 2005: p74). Cesar Palha de Sousa, biomedical scholar and influential figure in local health planning, argues that indigenous medicine has no classification of illness. In chapter five I show that this medicine has health and illness typologies and epistemologies. Misrepresenting indigenous medicine as having no classification of illness has political effects. Who determines the way diseases are classified is not 'value free'.

Ronguane (2008) and Palha de Sousa (2005) overlook the social context of therapeutic choice and delivery. Claims to scientific knowledge that reify biomedicine, stress its professional bureaucratic system of accreditation of medical practitioners and their legitimacy to practice, but overlook the knowledge related to indigenous medical epistemologies, are not 'value free'. They are just forms of misrepresentation which must be subjected to analytical scrutiny.

⁸¹ Professor of public health, and head of the department of public health at the Eduardo Mondlane University in Maputo. Former head of several influential departments at the Ministry of Health.

Many of those I interacted with, such as the professionals from the newspapers and local TV channels continued to despise indigenous medical practices calling them *curandeirismo*. Moreover, with very rare exception, of the journalists who attended seminars about indigenous medicine, I did not find any evidence that they knew about the Traditional Medicine Policy. They continued pursuing a line characterised by disparaging colonial and socialist representation of indigenous medicine. The Media also had new forms of representation shaped by Pentecostal⁸² approaches in which old idioms are represented within despising discourses of *curandeirismo*⁸³.

There was an increase in the popularity of Pentecostal churches in the 1990s following the end of the civil war and introduction of freedom of association and religion. Among them, Brazilians are prominent and fully integrated in the urban settings (Van de Camp 2011). Brazilian Pentecostalism in Mozambique preaches a philosophy based on hatred and defamation of indigenous medicine. Indigenous healing and the *tinyanga* represent competition in the control of health problems and is a rival form of knowledge based on sociability with a diversity of spiritual agents, which controls or challenges the spaces they see as rightfully occupied by the Holy Spirit and Jesus Christ. Amid accusations of their invasion of public spaces such as cinemas, television and radio (see Van de Camp 2011) and of “money stealing” from the followers through the excessive and mandatory tithe (*dizimo*), local discourses argue that the operations of the Brazilian Pentecostalism in Mozambique are supported by the regime. The actions of the government reinforce this argument. For example, for a very long period of time, the main Brazilian church in Mozambique, the Universal Church of God (IURD), rented space in the main building of the FRELIMO’s party. At the end of my fieldwork, in September 2011, Mozambique’s Prime Minister attended the biggest ceremony ever organized by IURD, called *Dia D* (Decision

⁸² Pentecostalism encompasses religious and churches that conceive a personal experience with god through the embodiment of the Holy Spirit by followers of Jesus Christ (Anderson 2004; Van de Camp 2011).

⁸³ For example, a local TV channel (*Mira Mar*) has widely watched programs called *Espeço Público* and *Balaço Geral* that uses this sort of wording and even lexicalise them in order to denigrate indigenous medicine.

Day), at the National Stadium in which the main objective was to perform miracles to manifest the wishes of the followers. This incited tough debates about IURD in the media, internet blogs, and web social networks in which people came together against the government. Lazaro Mabunda, local journalist from the newspaper *O País*, for example, put it this way:

“The government mandated the Prime Minister, Aires Ali, to testify and legitimise the miracles performed by the Universal Church of God (IURD). I am becoming more convinced that the financial capacity of the Universal Church⁸⁴ not only controls the political, judicial and financial systems, the press and parliament, but it also manipulates them. Akin to the mafia, after the press and parliament, IURD will control the country and dictates the rules of the game, in all sectors (...) I do not understand how any responsible government would support the activities of a religious group that preaches the idea that traditional medicine, used by the majority of Mozambican people, is diabolic and not recommendable (...)” (In *O País* 07.10.2011).

Mabunda continues by arguing that the Prime Minister Ali's acts were at odds with government policies and the creation of the Institute of Traditional Medicine (IMT⁸⁵) by the Ministry of Health in 2009, which valorises this medicine and acknowledges its contribution in health development.

The health field is also not a homogenous community of practice, as particular approaches and policies may suggest. When it comes to putting the policy and ideologies into practice, the dynamics show that different players have multiple, diverging and complex interests and conceptions of what a health service is or should be. For instance, Pentecostalism became a modern instrument and weapon through which indigenous medicine was represented and combated, even though it faces some local ‘resistance’ due to its financial demands and attitudes towards indigenous medicine. Between 2000 and 2005, the Ministry of Health and the biomedical practitioners didn't share the same ideology about health care provision either. People at the

⁸⁴ In local interactions IURD is just called Igreja Universal.

⁸⁵ Instituto de Medicina Tradicional

DPMMT had a pragmatic view about the availability of different medical practices but despite their intentions, they struggled to implement the WHO recommendations and the policy of traditional medicine. During my field work I interacted and interviewed a very excited professional at the DPMMT. Their plans had included the regulation and development of indigenous medicine but the Minister finished his term without even meeting with them, despite several requests made by the department for an audience. It seems that the (2000-2005) Minister of Health understood the so called 'promotion' of indigenous medicine to be at odds with his ministry.

There was no coordinated plan to implement the indigenous medicine policy, and the DPMMT did not have the resources to carry out a kind of implementation that would bring about visible changes. In reality, those in the health field had different interests and logic, with disconnected actions in relation to the policy and the degree to which indigenous medicine should be developed. At that time, at the National Institute of Health, where the DPMMT was located, different stakeholders were fighting for power to control the department and were claiming different rights and status to direct it based on their academic qualifications. This contributed to the dispersion of skills, knowledge and even the will to pursue actions that could mediate with indigenous medicine. Some biologists working at the department for example were not under direct supervision of the Head of the Department and were implementing parallel projects on indigenous plants development with the consent and coordination of different internal hierarchies.⁸⁶

Policy implementation had also revealed divergent epistemologies between health planners and the *tinyanga*. In order to deal with indigenous medicine, the health planners, in effect, supposed that many indigenous medicine practices could not be scientifically explained. This is not

⁸⁶ These accounts are from my participant observation. I will not disclose the names of those involved due to the sensible nature of this issue.

surprising, taking into consideration that almost all planners at the DPMMT were biologists and chemists for whom the most sensible way to pursue a line of inquiry was to exclude all non-material dimensions of the plants, and locate the efficacy in the phytotherapeutic properties that engender bodily transformations in the patients from disease to health. This approach was contradictory since the *tinyanga* also stressed explicitly the persuasive, symbolic and performative components of the plants, which comprise norms and rules to which the remedies are submitted in order to acquire their therapeutic value (Mahumana 2006). During my work with the DPMMT I realised that the philosophy of the researches at the DPMMT was based on a concept of 'medicine' as the administration of substances whose active ingredients might be isolated, tested, and validated in the scientific laboratory. This confers with West's (2005) observations. The promotion of indigenous medicine here becomes a paradox since it is carried out while rejecting the symbolic aspects intrinsic and intimately associated to indigenous health practices and representations. They are reduced, and devaluated since their intrinsic values and healing power are ignored, and with this the *tinyanga* capability to heal is taken away (Meneses 2000). Biologists, chemists and central planners do what they are trained to do. Knowledge making and science have entered the public health field and informed the techniques and strategies by which health, illness and efficacy is represented.

4.3.2. Associations of 'traditional' medicine

The former socialist regime did not provide a fertile environment for the cultivation of civil society movements hence it was only in the 1990s that Mozambique witnessed the emergence of these types of organisation. Mozambique's democratic constitution that emerged in 1992 regulated the creation and integration of civil society organisations within the new legal and administrative framework. All organisations that drew people together to pursue a specific type of common interest were legally registered as associations.

The 'Chilembene letter' of 1977 apparently stopped the persecution of the *tinyanga*. The interactions with the Minister of Health and future subsequent developments instigated the *tinyanga* to turn their organisation into an association. In this new, era State-sponsored legal services were used to legalise the Mozambican Association of Traditional Medicine/Associação de Medicina Tradicional de Moçambique (AMETRAMO) as a national association. In line with the legislation, their statutes have been structured to include a Board of Directors, General assembly and a Council of Auditors. AMETRAMO was designed to operate nationwide and enable the *tinyanga* to come together in a more organised way regardless of their types, sex and age. The neoliberal thinking was that good indigenous medical practices could be accessible and could develop if the practitioners were well organized.

During the socialist era 'associations' were considered to be part of the regime/party and organised in *Organizações de massas*/Mass organizations. As with other interest groups such as the Mozambican's women association/*Organização da Mulher Moçambicana* (OMM), and the Mozambique's Youth Organisation/*Organização da Juventude Moçambicana* (OJM), the work of the Organisation of *tinyanga* (AMETRAMO) was strictly connected to the ruling party. For example, they used the party facilities (*comités do partido*/committees of the party) at the local level (urban districts, administrative posts, and districts) and other locations that were well connected to the regime to carry out their activities. In this scenario there was a fabricated consensus that, for example, OMM was synonym of Mozambican woman, OJM of Mozambican youth, and, as such AMETRAMO became synonym of Mozambican *tinyanga*. In people's imaginary and everyday representation of group dynamics, for example of women, youth and *tinyanga*, the concept of these organizations, did not refer to restricted categories of associates but instead to every Mozambican women, youth and *tinyanga*. Local discourses now (incorrectly) regard AMETRAMO as synonymous with indigenous healing, and representative of all Mozambican *tinyanga*.

Considering the establishment of such associations, it would be questionable to assume that the government organised the *tinyanga* for strictly health purposes. It is more sensible to consider this as a strategy for a political control of the masses. This governmentality conceived of indigenous medicine (and other 'traditional practices') as a powerful political knowledge, with the capacity to control people and take on followers, and as such it should be continuously controlled for political purposes. They did this via AMETRAMO, as they did with former *organizações de massas*. More recently OMM and OJM were turned into civil society organizations affiliated to the FRELIMO party.

The liberalisation of the market and promotion of freedom of speech and information led people to express their interests within AMETRAMO and challenge its representativeness of all *tinyanga*. This 'imagined community' (Anderson 1991 [1983]) underwent internal contestation and disputes and it was claimed there was lack of transparency and accountability of the board of directors⁸⁷, disjunction between the organisational structure in the statutes and the way the association operated on the ground, in particular regarding the traditional generational, power relations and social diversity. Until the end of my fieldwork, for example, AMETRAMO's leaderships at the local level were collecting monthly fees (*quotas*) from the members for their personal benefits, the money was not accounted for, and was not going through transparent treasury procedures. I witnessed local meetings where there was no basic infrastructure in place such as furniture and toilets, and it was not clear how the money being collected by the president and his staff was being spent. When travelling, the national president collects money in every province to bring to Maputo City. However, their national headquarter in Xipamanine (Maputo municipal district Kamabukwana) also had no basic infrastructures in place. AMETRAMO was not achieving the organizational development of indigenous medicine desired by its creators and other

⁸⁷ As claimed by the associates

stakeholders⁸⁸. Nevertheless, the structure prescribed by the law for associations is akin to the State structure, hence very top-heavy in terms of the infrastructure, human resources and logistics needed to operate as a modern form of organisation. It would need new forms of bureaucratic knowledge, financial recording and transparency, which AMETRAMO leadership did not seem to have, in order to avoid incompetence, internal corruption and fights between members. In this scenario, and amid the new democratisation paradigms, the first board of directors headed by Banu Idrisse (*nyangarume*) was contested and the whole board was ousted in internal elections hosted by the Ministry of Health and organised by the Mozambican League of Human Rights/*Liga Moçambicana de Direitos Humanos* (LMDH)⁸⁹. In these elections Zitha became president of the board of directors, Langa vice-president and late Dzimba president of the general assembly. During my fieldwork I saw no signs of improvements. The board was replaced by new faces but AMETRAMO continued to be weak in its representation of the members and its transparency of how their money was being spent. The majority of *tinyanga* I visited during my fieldwork had attended meetings regularly in the heyday of the movement and now no longer attended. Meneses (2000) associates this decrease in membership affiliation to the liberalisation of both indigenous and biomedical services. Whilst this may be a factor to consider, I argue that one of the main reasons why the *tinyanga* have reduced their affiliation to AMETRAMO is the discontent due to a lack of transparency and relevance. As Mariana Dzimba points it out: “*Nowadays one dies and the relatives lack support even to carry out the funeral*

⁸⁸ A number of local stakeholders were interested on the organisation of AMETRAMO for different reasons. I participated in some discussions at the Foundation for community development/*Fundação para o Desenvolvimento da Comunidade* (FDC) and National AIDS Council obsessed with finding ways to organise the administration of AMETRAMO in order to allow it to properly host funding for HIV & AIDS campaigns.

⁸⁹ The LMDH is one of the few local institutions that has been publically defending that the lack of organisation of AMETRAMO leads to violation of the human rights by the *tinyanga*.

*services! What is AMETRAMO worth in that case? But they collect money every month?!"*⁹⁰ – Fieldwork interview, 2010.

The ousted Chair of the Board, Banu Idrisse decided to form a new association called *Ervanária* (herbalists) capitalising on the support she had from networks of the *tinyanga*. This association focused its discourse on herbal medicines although the membership also includes mediums. The establishment of such an association demonstrates that the *tinyanga* themselves had started to reproduce a formal representation of an indigenous medicine as reduced to medicinal plants. In their daily activities they practice health paradigms in which the role of spiritual agents and rituals remains the main *materia medica* but in public interventions they portrayed the importance of medicinal plants and corporeal sicknesses.

The subsequent years witnessed the emergence of other associations of indigenous medicine in more specialised fields and interests. In my fieldwork I engaged with the Spiritual Group/*Grupo Espiritual*; of mediums and herbalists, the Association of Mozambican Indigenous Medicine Sellers/*Associação de Vendedores de Medicina Tradicional de Moçambique* (AVEMETRAMO); with a focus on the selling of herbal medicine, and Promotion of Traditional Medicine/*Promoção de Medicina Tradicional* (PROMETRA); for people specialised in different fields of knowledge and working in the development of indigenous medicine.

In 2007/8, under the auspices of the DPMMT, a Forum of 'traditional' medicine (Forunta) emerged that brought these organisations together with individual and specialists of Asian medicine. The understanding was that this Forum would have a coordinated common voice in dialogues relating to indigenous medicine with different stakeholders, including the government. On some occasions this was effective, for example when it coordinated a contribution to the

⁹⁰ "Namuntlha wena whofa maxaka mapfumala ni wakumalahlisa! Akwini AMETRAMO nkama lowo? Kuve male vateka wheti ni wheti?!"

elaboration of the second HIV & AIDS strategic plan, which was coordinated by the medical doctor Hélder Martins, first Minister of Health of independent Mozambique. He was now a consultant for the National AIDS Council (CNCS)⁹¹. The Forum lobbied for a change in the top down process of consultation, as well as a medical pluralisation of the strategic plan. After heavy discussion on representation of health/illness, in which the *tinyanga*, most of them with no formal education or training on health issues, tried to demonstrate how indigenous medicine should be portrayed and given prominence along with biomedicine in the plan, it was decided that, within 10 days, the Forum should outline its ideas on how to fight against AIDS. After 5 days of hard work and significant contributions from the associations hosted by the DPMMT, this was sent to the CNCS, but none of the contributions was integrated in the strategic plan. This strategic plan to combat HIV/AIDS came out representing biomedicalised public health and interventions. Indigenous medicine was only mentioned once, but cast as a conglomeration of cultural practices that influenced people to resist to the biomedical health offers of the State (See PEN II).

Notwithstanding the fact that the Forum (Forunta) mediated with indigenous forms of illness representation and diversity, it began to crumble when the nominated coordinator - a lawyer working at the Ministry of Health who was also a *nyamusoro* but not affiliated to any association - decided to turn it into the legal representative of all group members. Forunta would then have become an association of associations of indigenous medicine and *tinyanga*. There was no agreement to this and some associations of indigenous medicine did not consent to the legal and institutional implications of this process. They were not prepared to accept the potential loss of voice recently acquired in the new diversification of expressions in the health field and the autonomy and independence prescribed in their internal constitutions and rejected the proposal.

⁹¹ Hélder Martins was accompanied by two other Mozambican consultants: a sociologists and an anthropologist.

4.3.3. CIDE and IMT

The government that took office after the 2005 elections brought two new actors into the health field: the Ministry of Science and Technology (MCT) and the Institute of Traditional Medicine (IMT). The latter worked under the Ministry of Health.

The MCT designed a Policy of Science, Technology and Innovation and the Mozambique's Strategy for Science, Technology and Innovation/*Estratégia da Ciência, Tecnologia e Inovação de Moçambique – ECTIM*. A national research program about Indigenous Knowledge Systems (IKS), was to be in place by 2015, and public health policies were to be developed through carrying out pure and applied research on indigenous medicine.

Some DPMMT senior state planners were unhappy with the lack of determination to develop indigenous medicine within MISAU and felt the department had been marginalised, and fled to MCT to work in the implementation of ECTIM. The Ministry created the Centre for Ethnobotanical Research and Development/*Centro de Investigação e Desenvolvimento de Etnobotânica – CIDE*. The former chief of DPMMT coordinated its creation and was the head of this Centre by the time I finished my fieldwork.

The Science and Technology Policy drew up its IKS (Indigenous Knowledge Systems) program in a strategic way. Those who were assigned to implement it have added new nuances and invented new linguistic devices for old cultural standpoints once used to represent indigenous medicine. In this setting the focus is on developing indigenous therapeutic products, *inter alia*, for beauty, and nutrition. Ethnobotany/*Etnobotânica* became the new idiom in which CIDE would research and process the products and generate sustainability. How would this new *Etnobotânica* conduct its research into the plants? How would it conduct its research into local knowledge about the plants that they were interested in? What are the implications of moving the

plants from the 'community' to the research and production site? In the next paragraphs I engage with these questions focusing on issues of 'mobility of medicines'.

4.3.3.1. Mobility and transformation of meanings of indigenous medicines

The study of medicines⁹² is of extreme importance for the understanding, planning and delivery of public health services⁹³. According to Geest et al (1996) this interest is due to the fact that medicines are, *inter alia*, social and cultural symbols, vehicles of ideology, facilitators of self care and perceived sources of efficacy. Researchers have accounted for the fact that medicines have both intrinsic chemical capacities that are used to engender bodily transformations, and socially constructed meanings (See Pool & Geissler 2005; Geest Et al 1996; Etkin et al 1990). For example, Poll & Geissler (2005) look at medicines as "substances of power", and assert that all medical traditions use medicines (their phytotherapeutic capacities) to produce bodily changes from illness to health. This capacity of medicines, the authors argue, makes them powerful substances, which therefore attract attention and are given meanings in different contexts where they are used.

Since medicines have different origins, significances and ideas attached to them, each social context, where these enter, gives them local meanings. Hence, they suffer transformations of meaning during their mobility within the diverse health care "systems", especially under the current era of globalization, when they are delivered almost everywhere in the world, bringing meanings with them which are transformed locally.

⁹² Any substance that, based on their inherent power, can be used to provoke transformation, such as the bodily change from ill-health to health (Pool & Geissler 2005). I may use the term pharmaceutical when referring to biomedical drugs, those medicines produced in the base of biomedical knowledge and industry; and the term indigenous medicines when referring to the Indigenous medicines, which are medicines in their "natural" form.

⁹³ See Geest Et al 1996 for a review of the studies of medicines in the last decades.

Etkin et al (1990) have examined the mobility and transformation of pharmaceuticals in Nigeria, and account for the fact that when biomedical medicines enter into Hausa indigenous medicine practice they are incorporated and transformed into local epistemology. The authors demonstrated that pharmaceuticals are selected, used and evaluated according to the aetiology of health/illness guiding this medicine. This adaptation of biomedical drugs to the local social and cultural environment is called indigenisation of pharmaceuticals (Pool and Geissler 2005). In my research into the work of CIDE, I understood that the local meanings of medicinal plants are changed in their journey to the laboratories. Local meanings stress explicitly the symbolic component of the plants, which comprises the ritual precautions to which the remedies are submitted in order to acquire the therapeutic value. The laboratory pursues a line of inquiry that excludes all non-material dimensions of the plants, and locates their efficacy in the phytotherapeutic properties that engender bodily transformations in the patients from disease to health. The journey taken by medicines when CIDE takes them from the indigenous medicine setting for researching them is called biomedicalisation of indigenous medicines.

Geest et al 1996 designed a very useful biographic model for medicines, which can be applied to reveal the “social life” of medicines in general. Following this line, medicines are produced and marketed, prescribed, distributed, used and their life ends when they accomplish their final mission, which is the healing effect. Each of these phases happens in a particular context and has its own actors, values and ideas (Geest Et al 1996).

In CIDE's research plans, *tinyanga* are identified with long-term experience in treatment, for example, of sexual transmitted diseases, diarrhoeas and other ‘opportunistic diseases’ associated to AIDS. Then surveys are conducted to gather data about types of plants and their utilisation for treating biomedical illness. The *tinyanga* are asked the name of plants and their samples are taken. In the process the samples are taken to the drawer located in a herbarium. Here they are identified according to the botanical taxonomy, classification and categorisation. In

the herbarium, information about the provenience, date of collection and usage is added. Thus, the plants are moved from where they are indigenous medicine, made into specimens and put into a botanical archival system. Afterwards, they are taken to the laboratory for phototherapeutic properties research. The CIDE team examines the medicinal plants in terms of chemical elements in relation to their effects upon human physical bodies.

The *tinyanga*, on the other hand, collect the medicines in the forest, rivers, lakes, sea or fauna and prepare them at the home “clinics”. The preparation includes boiled and/or unboiled medicines, dry or fresh elements, and powders. After these preparations, the medicines are ready to be used to engender change from illness to health. But indigenous medicine represents personhood and health in terms of relationships between human beings, ecology, ancestors, and clean blood (See chapter V). This means that the social and “natural” words are embedded in a unified cosmological universe, which guides the practice of the medicine. This epistemology influences the representation and classification of indigenous medicines, and their perceived locus of efficacy. Consequently, the pharmacological elements of the medicines are not separated from the performance of the therapy and symbolic component as their efficacy also rests upon it. The performance of the therapy and symbolic component include the communication with the ancestors in presenting them the medicines and the related concatenation of symbols and symbolism. The *tinyanga* and their patients attach these values to the medicines in the production, distribution and somehow in the utilisation process. Therefore, the meaning given to the medicines locates their efficacy in an array of different models of efficacy in terms of healing. The medicine and its meaningfulness as a healing agent, influences the patient’s mind, activities and social world through its association with the *nyanga*. It is also a powerful substance known to engender bodily changes. However this power is not seen in isolation, instead it is generally associated with the ancestors being in harmony with the living (see chapter V).

In summary indigenous medicine accommodates, categorizes and gives different meanings to medicines, and medicinal plants in particular. They “live” in domestic and unofficial networks since they are collected, prepared and distributed at the home based “clinics”. Here the efficacy attributed to them is commonly associated with the performances of the therapy adopted by both the *tinyanga* and patients. They are given a different trajectory when taken to the herbarium where they are reshaped and sent for rebirth, at the laboratory. From the time they enter the herbarium, the same plants are made into specimens and put in a botanical system. After that, the laboratory receives them in the light of this new meaning, which accommodates them as single biochemical substances. This is the way the indigenous medicine become biomedicalised at CIDE.

In 2010, in line with the 2004 policy of traditional medicine, and six years after its declaration by the former administration, the 2005-2010 Ministry of Health created the Institute of Traditional Medicine/Instituto de Medicina Tradicional - IMT⁹⁴. The biologist Felisbela Gaspar of the now extinct DPMMT was nominated director. This institute proposed a strategy that encompassed a remarkable roll of activities to be carried out in the next years, *inter alia*, promotion of the utilisation of indigenous medicine, education and training of *tinyanga*, promoting primary healthcare services, legislation development, regulation of intellectual property rights issues, promotion of research, and capacity building of the IMT.

Since its inception, the IMT has been working in a non-participatory way, excluding some important actors in the promotion of indigenous medicine in Mozambique. Important figures, and associations and NGO's with knowledge on indigenous medicine and education skills have not been consulted in key issues or involved in actions and consultations that are defined by the IMT

⁹⁴ MISAU. Diploma Ministerial nº52/2010, BR 11, de 23 de Março de 2010

as participatory. My own employer, PROMETRA and other associations⁹⁵ were not approached by the IMT, and attempts to collaborate with it failed. As the Institute does not have *tinyanga* on the staff, a more inclusive involvement with the practitioners might be expected, enabling them to draw on the knowledge and experience of these important stakeholders. The IMT is, instead, using top down methods and diverting the attention from the most affected by the promotion of indigenous medicine; the *tinyanga*. This top down process and exclusion gives way to reinvention of an indigenous medicine that is not contextually relevant.

In its strategic approach, the IMT also intends to integrate **some aspects** (my bold) of indigenous medicine in biomedical institutes and universities in order to sensitise those who are being trained in biomedical forms of reasoning on issues of indigenous medicine. In terms of efficacy, this approach intends to integrate those practises of indigenous medicine considered (by the Institute) to be safe into the hospitals practice, yet according to their own approaches and methods. In this context, efficacy will be what the IMT judges to be capable of healing their illnesses in their standards.

The education and training of the *tinyanga* at IMT focuses on a number of things including endemic sickness, such as leprosy, malaria, HIV & AIDS, and tuberculosis, referring patients to hospitals, finding areas for cooperation between indigenous medicine and biomedicine, the production of didactic materials for training the *tinyanga*, and on training in safe management and trading of indigenous plants. The typologies of illness targeted by the training activities are biomedical. Most of the proposed activities do not involve the knowledge of the *tinyanga* in the training processes. The *tinyanga* are being trained by biologists and chemists with no involvement whatsoever of experienced *tinyanga*.

⁹⁵ Some association requested anonymity.

In the promotion of primary healthcare services the IMT envision producing written material concerning nutrition and stimulating the production of certain medicinal plants. Primary healthcare is thus reduced to plants once again, and indigenous medicine is seen to be efficacious only at this level. It is not clear how they are going to involve the *tinyanga* in these primary healthcare services and it is implicit that herbal medicines will be introduced in hospitals (?). Thus the institute is interested in disembedding the indigenous plants and nutrients, and giving them new meanings and model of efficacy in the ONHS.

The IMTs aspirations in issues of legislation, development and regulation of intellectual property rights is remarkable in it's intent. It envisages the mapping of *tinyanga*, the elaboration of legislation for practice, the protection of its knowledge and care for its biodiversity base. I did not see in my fieldwork, and in IMT's strategy, specific knowledge about and willingness to mediate with the way indigenous medicine represents illness and efficacy. This – and the lack of participation - is its main handicap within the therapeutic landscapes.

The capacity building of the IMT includes staff trained in biology, chemistry and ethnobotany. There are no plans to train staff in areas that use different paradigms and could incite alternative standpoints.

In research development the IMT essentially shares the same tenets with CIDE, including the concept of ethnobotany. However, by the time I finished my fieldwork the IMT did not have laboratories like CIDE. Since both CIDE and IMT in the end use the same rationalities to represent illness in the health field, it is likely that the Science and Technology Policy and the Traditional Medicine Policy will continue to represent biomedical illnesses and efficacy without reflecting that within the context of indigenous medical practise in Mozambique.

In local medical landscapes, plants have a peculiar classification, constructed within an epistemology that relates to the healing process. When they arrive at institutions associated with

biomedicine, they gain new interpretations associated to the epistemology of this medical tradition. Overall, the plans at CIDE and IMT aim to identify plants used by the *tinyanga*, do biochemical studies, agrobiologic examinations, evaluate their therapeutic efficacy, and take those which show efficacy and extend their use. Local medicines based on plants, it is asserted in leaflets, strategic plans and reports, are affordable and can reduce the dependence on pharmaceuticals. However, it is not outlined how indigenous medicines will be made available for the patients and nor it is indicated whether it will use the biomedical “system” or the indigenous one for the distribution stage. The indigenous health care “system” is not planned by the state so that it can deliver medicines systematically. For this reason, and because it was shown above that the IMT excludes the *tinyanga* and wants to introduce the medicines in hospitals, it is assumed that the distribution stage of the medicines will be done at the current biomedical ONHS.

CIDE and IMT plans will change the context of medicines from ‘home’ health services of indigenous medicine where they are produced and delivered to the patients and make them pass through the herbarium straight to the laboratory. The medicines will also change the actors with which they share their life since they are given to biologists who, as aforementioned, identify them according to the botanical taxonomy. Afterwards, the plants are taken to the laboratory for the research into their phototherapeutic properties by the team of biologists, chemists and medical doctors. No *tinyanga* or social scientists are part of the research plans and process.

The ethnobotanical plans of CIDE and IMT aim at developing indigenous medicine but, instead, they frame this development in biomedical meanings and are not epistemologically sensitive to the way in which medicines are given meaning in indigenous therapy. Hence, they are more likely to reinforce health inequities given that the appropriated plants cannot be expected to return to the meanings, frames of reference and health practices of indigenous medicine.

4.3.4. Representing belief and resistance

Health campaigns and health professionals in Mozambique see some indigenous health practices as forms of ignorance and cultural beliefs that lead people to ‘resist’ effective, true and appropriate biomedical knowledge and practice.

It is said of mothers, for example, that the indigenous types of illness represented by mothers do not exist, and that the mothers invent the illness because they have no formal education and no knowledge about children’s ailments (medical doctor Eliana Ferreira, in *MozCeleb*, Issue 1: 93). Eliana Ferreira gives the example of *mavhabzi ya wheti* (epilepsy). What she seems to ignore is that as previously explained in indigenous medicine this sickness is known to be caused by an agent known as *nyokana* which ‘lives’ in the human blood and body in harmony with the moon (*wheti*). When the moon shows up children are more affected than others until they become teenagers. Some children can develop the *mavabzi ya wheti* but others don’t. It seems unclear whether Eliana is ‘resisting’ understanding the representation of *mavabzi ya wheti* or reifying her knowledge over the knowledge of the mothers, which is based on indigenous medicine epistemologies.

The act of resistance to “proper” health services also emerges in local discourses that stress issues such as the use of blades, accusing the *tinyanga* of reusing the same blades when they *tlhavela*⁹⁶ their patients. I did not encounter *tinyanga* using same blades and I noticed that they are aware of the need to use disposable blades for each patient or person. A significant example comes from the graduation ceremonies which I participated in Maluana. The three (possessed) candidates line up for the *kuparura*⁹⁷ graduation and a cohort of *vab’ava*⁹⁸ allocate similar

⁹⁶ ‘Vaccinate’

⁹⁷ The Ndau graduation for *nhamusoro*/medium.

⁹⁸ Teachers/masters of the *vanhamusoro b’andla*/school (plural)

vaccination tasks for each of the teachers. This was normally performed by the host *b'ava*⁹⁹ alone but in this ceremony the old spiritual brother of the host *b'ava* said:

“vab’ava lets ‘vaccinate’ them all at the same time to skip this blade issue and gain some time
(...) men ‘vaccinates’ the male *twasana*¹⁰⁰ and women ‘vaccinates’ the female *twassana* (...) / (...)
vab’ava ahivatlhaveleni hi nkama wun’we hitaka hingajunteli tinavayi hiva higanya nkama (...)
vab’ava n’wine vaxinuna tlhavelani vanuna kulobze, avavasati vatlhavela vasati kulobze (...)” -

Carlos Magaia, Manhiça, Maluana, 14 of May 2011.

By distributing the tasks this way they used different blades and had redesigned the ceremony. It is possible that in some remote areas (and perhaps cities) the *tinyanga* may still be using the same blades to vaccinate their patients because they do not have access to new ones (or to safety information), in contrast with their biomedical counterparts who receive support in the form of information and surgical equipment. One alternative way to solve this problem is realising the right to access to State support whereby indigenous medicine would be supplied with these sorts of basic resources in order to deliver safe healthcare services. Falmer (1997), in his study about HIV & AIDS in Haiti, accounts that some people are forced to perform certain social practices the way they do due to constraints on behaviours and options imposed by institutionalised inequalities in wealth, social mobility and power.

In my research I also noticed that patients themselves from Maputo comply more with the strategies preventing surgical infection by HIV in indigenous medicine than they do with sexual infection and within hospitals. When they have no previous experience or trust with a *nyanga* they bring with them new blades for any vaccination. During my practice and fieldwork, I realised that this habit is becoming common regardless of the familiarity with the *nyanga*. In the hospitals, in

⁹⁹ Teacher/master of the *vanhamusoro b'andla*/school (singular)

¹⁰⁰ *Nymusoro* Student/Candidate to *nyamusoro*

turn, patients are “surgically controlled” and they are not left with space to control their bodies or negotiate vaccinations.

In the statement previously quoted, the vice-minister of health said that *murhi wa wheti* was a belief and associated it to resistance to the hospital, emphasising that this medicine does not exist¹⁰¹. Her declaration is mistaken because the manipulation of this medicine is intrinsic to local childcare practice within the households. Moreover a trained *tinyanga*, especially those I encountered in my research, know why, when, and how to medicate children. *Murhi wa wheti* is a medicine for preventing *mavabzi ya wheti* that is given to children after two months of life. People of different social status in Maputo and Manhica, and across the country, have been medicating *murhi wa wheti* to their children regardless of this official propaganda, and they perceive it to be a good agent to prevent and/or heal the *mavabzi ya wheti* (similar epilepsy). The efficacy of this medicine lies in the therapeutic fabric and experience of indigenous medicine but not within biomedicine and public health planners’ imagery. It is according to these people’s lifeworlds that it has to be represented, and its efficacy verified.

The concepts of belief and resistance are essentially propositions, claims of power, and types of persuasion and stereotyping that suit those who represent them more than those who are said to practice them. Local actors who represent resistance continue seeing indigenous medical categories as *folk beliefs* with no ontology. Basically, local epistemologies of health/illness are seen as being irrational due to ignorance, superstitions or traditional views that diverge with

¹⁰¹ “We have decided to constitute the Institute of Traditional Medicine in order to identify harmful practices and turn them into positive practices. For example, the belief that newborn babies have to take medicine for the moon¹⁰¹ is wrong and harmful because babies should only take the mother’s milk until they are three months old and this disease does not exist at all (...) It derives from bad practices that we are sure we will eliminate with this institute because they are resistance to good practices of the hospital (...)” – 31ST of August 2010, *Telejornal*, Mozambique Television (TVM), 31st of August 2010.

biomedical knowledge (Falmer & Good 1991). The very term resistance, for instance, is problematic since it is not grounded in ethnographic material to support its significance, and is associated with the belief of the existence of a dominating modern power and resistant subjects to its ideology (Ortner 1995). “Yet such analyses can easily fall foul of the problem that Ortner (1995) identified more generally in resistance studies: the thing resisted is often of assumed but not demonstrated significance.” (Fairhead et al 2006: 1110). Resistance reasoning can deny voice and the autonomy to other epistemologies. People do things because of their own logics and experience.

4.4. Conclusions

In this chapter I explored the social and historical foundations of the representation of health/illness in Mozambique and have shown the different ways in which indigenous health has been (mis)represented by local stakeholders.

In summary I found continuities between the colonial and postcolonial regimes in relation to the hostile treatment of indigenous medicine in which it was cast within derogatory language. The former created a very sophisticated legal and administrative apparatus to manage a social discriminatory system that swept away indigenous health and healing from the state spaces. The latter just changed the control of the means and modes of production but was also discriminatory and reinforced the stigmatisation of indigenous practices. The colonial and postcolonial regimes used biomedical philosophical and methodological approaches to health and illness supported by colonial positivism and religion, and socialist scientific materialism, respectively. However between the two eras there were some discontinuities in the representation of indigenous medicine because the revolutionary leaders, unlike their colonial counterparts, faced formal opposition from the *tinyanga* and their cultural identification with indigenous medicine and political need for legitimisation created a gap between ideology and practice that ended up in the recognition of indigenous healing. The two main final outputs of the two eras are: (1) the

recording, in the uses of Portuguese language, of colonial and postcolonial derogatory expressions used to classify and stigmatise social reality, and (2) the emergence of a schizophrenic society of people living in two social worlds, one 'authorized' where indigenous healing is denigrated, and the other, in which people use indigenous medicine and pretend it to be non-existent, while it is in force in social practices.

In the analysis of the approaches to indigenous medicine in the neoliberal era I have shown how external impositions of the neoliberal capitalist model and 'western' democratisation reshaped discourses and representations of indigenous medicine. Here I gave accounts of the emergence of state institutions and associations that came to connote new modernities of health. In this modernity, indigenous medicine is captured but biomedicalised and parted from the context of the *tinyanga* in the appropriation process. *Tinyanga* fashion the state biomedical discourses but this is at odds with their practice and they struggle to navigate within the new administrative landscapes imposed by the neoliberal era.

In this neoliberal era the stakeholders participating in the Mozambique's health field employ different approaches in order to deal with indigenous medicine. These approaches are summarised as follows: the representation of belief and resistance, epistemicide, religious neo-colonialism, and biomedicalisation. The representation of belief and resistance are discourses that accuse patients and the *tinyanga* of representing the absurd and of resisting to biomedical health offers. This representation precludes the existence of indigenous medicine as a form of knowledge and lacks ethnographic evidences to substantiate its claims. The epistemicide (Meneses 2000) encompasses the ways through which the stakeholders, through well-organised apparatus, endanger, transform and try to extinguish the epistemologies of indigenous medicine in the health field. Religious neo-colonialism denotes the combat and displacement of indigenous health practices through Pentecostalism in order to keep the hegemony of the Holy Spirit and power of Jesus Christ in local spaces and bodies. In biomedicalisation, sickness is conceived in

terms of bodily processes and indigenous medicine condensed to medicinal plants reducible into biochemical healing agents that can be directed to physical bodies suffering from universal biomedical sickness.

In order to overcome the bias and inadequacies imposed by the previous perspectives I embrace a different approach to inquiry into – and the framing of – health/illness.

4.4.1. Towards social experience

The positivist thinking assumes that science is the study of an objectively existing reality that lies outside the discourse of science itself, and that this very reality can be reduced to observable phenomenon. This notion encompasses, *inter alia*, objectivism, dichotomy between the truth of science and reality, as well as reductionism of phenomenon into ‘observable’ units. This leads to the empiricist way of looking at that objective reality by the means of the experimental method (Delanty 2005; Good 1994). The biomedical perspective claims an objective empirical order of biological universals, and strongly emphasises the use of language to depict health and illness. Discourses about health and sickness in Mozambique are informed by this perspective, which dominate the public health field, and are supposed to be applicable to all social reality, forms of medicine and health-seeking behaviour. In this perspective spiritual agents for example are said to be invisible, hence not scientifically analysable.

The question of whether spirits exist or not raises big methodological and epistemological problems to its proponents. Answers depend on which method or strategy of inquiry is used. They are invisible for those who categorise reality according to material derived from a sort of social physics. People who dare to look for spirits in the microscope or a vacuum of reduced ‘observable’ units will not find them because this is not the appropriate instrument and method to inquire into them. If scientists sought for ancestors and spirit possession in social events and practices, they would find that spirits are a social fact. Regardless of their different approaches,

some of which I do not agree with, ethnographies conducted worldwide have portrayed spirits to be a phenomenon found, among other things, giving orders to people, shaping the production and reproduction of social life, health and illness, reproducing performative life, and constituting part of the *materia medica* that negotiates health, sickness and therapy in indigenous medicine (Boddy 1994; Crapanzano 1977 & Garrison; Honwana 2002; Lambek 1989; 1993; Stoller 1995; Sharp 1993). The material invisibility (?) of the spirits should not be used to deny their ontology as a social phenomenon that shapes society and people's health-seeking behaviour.

The history of production of knowledge has shown that the historical context determines what at any time can be seen and legitimized as the authorized truth (Foucault 1989). Michel Foucault asserts, for example, that the biomedical claims of truth and the reification of the separation of the physical body from the mental and social is historically contingent, with its roots in the philosophy of the French philosopher René Descartes.

Those attentive to phenomenology and to the history of social sciences have severely criticised positivist approaches to epistemology for bracketing off social aspects and human experience (Foucault 2005; Jackson 1996; Kuhn 2005; Weber 2005). The interpretive approach also suggests that natural science studies objects with no intrinsic meaning, while social science studies a domain in which the meanings and understandings of actors play a central role (Weber 2005). For phenomenology, social inquiry must focus on grasping the understandings of actors, instead of explaining their behaviour in a causal, 'scientific' fashion. They argue that it is possible to incorporate the views of actors while still looking at the causes operating in the social world. By focusing on actors, phenomenology overturns positivist assumptions of superiority of the empiricism and the experimental method over social practices and other forms of reasoning.

Phenomenology strongly emphasises that any theory aiming at explaining social reality has to stand on and develop methods very different to the natural sciences in order to be in agreement

with people's experience of the social world (Jackson 1996). In the same path histories of sciences ask us to look at medicine putting the patients at the centre of analysis instead of doing public health from the perspective of the academics, health planners, and doctors (Foucault 1989).

Social sciences, especially anthropology, contributed greatly to the twentieth-century sociology and the history of knowledge by arguing that human knowledge is social, and governed by cultural rules, and that medical knowledge is not an exception. The study of public health, illness, healing and medical knowledge needs to inquire into how particular cultures and practices formulate reality in distinctive ways and how knowledge claims are organized vis-à-vis these distinctive forms of reality (Good 1994). In the next chapter I will look at how people from Mozambique experience health, illness and therapy.

CHAPTER V - THERAPEUTIC LANDSCAPES: INDIGENOUS MEDICINE

5.0. Introduction

In this chapter I reveal the specifics of indigenous medical practices in Maputo and Maluana. From the perspective of the patients, there are no bounded “medical systems” within the therapeutic landscape but health practices, knowledge and experience. The argument is that those health elements typically associated with indigenous medicine have been misrepresented and undocumented. They need documentation in order to make sense of their historiography and as a basis for the debate about illness representation and efficacy. Drawing from praxis and experience, this chapter looks at the way people in these two places represent health, healing, therapeutic knowledge and efficacy of indigenous medicine.

I will demonstrate the way in which indigenous medicine and patients use a different epistemology of medicine to that attributed to them in current debates. It is important to note that although the health practices of indigenous medicine are shared by the majority of Mozambicans, they cannot be assumed to be shared by the whole society since people are exposed to different social networks, objectives and ecologies that create different cosmologies and social heterogeneity. In addition, knowledge and practices of indigenous medicine are not homogenous and vary from one group of *tinyanga* to the other, with some more expert than others in the different fields. The knowledge presented in this chapter is representative of the *tinyanga* practice and their community networks. Firstly because there is no homogenous cultural practice since variation and diversity is intrinsic to social phenomenon and medical practice. Secondly, the medical knowledge portrayed here is intelligible among local *tinyanga* and patients within local therapeutic landscapes. The *tinyanga* and patients grasp both the propositional and social meanings of the medical practices, and agree that they belong to the same therapeutic landscapes, and historical and social (medical) tradition.

This chapter presents an ethnographic account of local representation of health, illness and models of efficacy and the community of practitioners and professional practice. I will firstly give a description of the main actors of the therapeutic process and the epistemology underlying their concepts of health/illness. Secondly, I present the sicknesses targeted by the healing process, the way they are diagnosed and how the *tinyanga* heal them. Thirdly, I analyse the models of efficacy.

5.1. Health and Illness

Local anthropological studies of health and illness in Mozambique stress a straightforward *dependence* between the living, the deceased ancestors and the environment. Health is defined in terms of harmonious relationship between human beings, environment, and the deceased ancestors and among the living within the environment. An imbalance in this relationship produces a state of illness which is not seen only as a physical problem. This distortion of harmony can be provoked by the deceased ancestors who can demand rituals and supplications from the living. People can also have their health jeopardized when they do not pay attention to their ancestors who are known to propitiate good health and wellbeing (Bagnol 2008; Honwana 2002; Granjo 2005, 2006). Whilst true, this is too general in the way it defines sickness, and makes a very straightforward association between physical sicknesses and spiritual (in)balance. The idea that illness is never a physical but always a spiritual problem has to be verified. For example, in what sort of physical bodies are the anthropologists researching the illnesses? Anthropological research in Mozambique needs to go back to the field to inquire on the basic categories that underpin local representation of health and illness.

In order to improve the understanding of health and illness of indigenous medicine I will focus on essential elements in the fabric of health, therapy and efficacy. Local representation of health and illness is rooted in the following interrelated and connected elements: (1) the local socio-cultural agencies and agents; (2) the local notion of personhood and its underlying categories, and (3) the

knowledge, and experience about illness, diagnosis, therapy and efficacy. The description of this network of categories will also aid improving the metalanguage used to discuss health, illness and therapy in the future.

5.1.1. The socio-cultural agents and agencies

The first important elements in local representation of health and illness are the socio-cultural agents and agencies. The former refers to spiritual agents. The latter are agencies such as kin groups and social structures.

5.1.1.1. Spiritual agents

An enquiry into spiritual agents has to look at both the principles underlying their history, typology and reproduction and at the relationships and experiences that different social agencies, households and communities establish with them.

In local epistemologies, the living and the deceased ancestors are part of the same social world. The human body boundaries are known to be built up by physical matter (*miri*) and their spirit (*xiviri*). When people die their *sviviri*¹⁰² leave their bodies and remain spiritually alive within the family and community. It is the responsibility of the living to reintegrate them back within the family and community. This social (re)integration can be the initiative of the living or demanded by the spiritual agents who can influence the living to comply with their demands. Their social integration includes the performance of *mhamba*¹⁰³, which encompasses different rituals reserved for each category of spiritual agent and the different purposes of each ritual.

Spiritual agents are characterised by their type, origin, designation, and kinship. Current spiritual agents encompass the *Vahlonga*, *Vaguni*, *Vandawu*, *Svikwembu sva matlharhi*,

¹⁰² Plural for *xiviri*

¹⁰³ Ceremony to integrate the deceased ancestors

Valungo and *Vabanyana*. As I shall outline in the next paragraphs, each of these are associated with the political, economic and social history of Mozambique and the southern Africa region, and local social memories of them. In particular they recall how modern Mozambique's history was characterised by two violent political colonisations, first by the Nguni group in the XVII-XIX centuries and later the Portuguese in the XVIII–XX centuries, and by one civil war between the 70s-90s of the last century. Each of these are directly associated to the origins of current categories of spirits and the type of relations they currently establish with the living.

The *Vahlonga* are spirits from the matrilineal and patrilineal lineages which gives them a typically endogenous status. The *Vanguni* (Nguni) and the *Vandawu* (Ndau) are categories of spirits that emerged and were introduced during the Nguni war and their domination throughout Southern Africa. This period is known in local history and social memory as *Nfecani*. The Nguni are foreign spirits by origin and were incorporated in the kinship structures of the *vahlonga*.

The *Nfecane* war originated in what is now Kwazulu Natal, in South Africa, which was the stronghold of the Nguni people. During *Nfecane*, the dominating Zulu King Shaka overpowered and expelled various Nguni groups. As they fled, some of these groups, with their highly sophisticated military strategies and capacities, migrated into different regions of Southern Africa and dominated local nations. The main Nguni group that invaded Mozambique, occupied the region from the south to the centre of Mozambique and created the Gaza Empire, first headed in Musapa¹⁰⁴ in the current Manica province and later in Mandhlakazi, Gaza province (Liesegang 1981). The Nguni in Mozambique developed social stratification and implemented assimilation policies in which the Nguni aristocracy

¹⁰⁴ Region of the Ndau group.

assimilated one subordinate class from the middle social strata of the local community, leaving a non assimilated group - turned slaves and captives - at the bottom of the social hierarchy. The majority of those assimilated into the Nguni culture participated in the political and military system. These people were also granted access to protection by the Nguni ancestral spirits (Honwana (2002). Local historical memories report selective patrilineal marriages between Nguni men and local women through which the Nguni granted social protection and entered into local kinship by becoming *vakon'wana* (sons-in-law). Oral accounts report that, in order to transform the Ndau region of Mussapa in the centre of Mozambique into their stronghold during this process of domination, the Nguni of the Gaza Empire massacred, enslaved and displaced the Ndau people. It is said in these oral accounts that the Nguni encountered difficulties in assimilating the Ndau on account of their strong sense of identity and vitality. The Ndau, like other social groups who resisted, were assassinated or dispossessed by the Nguni elite and assimilated by force. Informants¹⁰⁵ relate narratives about their great grandparents (many generations ago) who were warriors in the Nguni campaigns and who brought avenging Ndau spirits into their home when they returned. These events took place in the XIX century. The histories recounted do not just concern brave, honourable warriors but also entail memories of premeditated killing, thefts and other such events that provided sources of hatred and vengeance.

The Nguni introduced a new type of spiritual agency. This category (*mungoma*), which apparently did not exist locally before, had the capacity to possess people. Since the spirits possess people and demand that they become *tinyanga* in order to work through them, this reshaped the local categories of *tinyanga*. The Ndau presence within the region also

¹⁰⁵ For example, 87th years old Carolina Machele interviewed on April 2010; 90th years old Obadias Chilaule interviewed on February – March 2010.

brought in a new category of spiritual agent; *Nyamusoro*. *Nyamusoro* spirits also have the capacity to possess people, turn them into *tinyanga* with the capacity of being mediums and doing exorcism. The new Nguni and Ndaou spiritual agents added to existing types of spiritual agents active in local social landscapes (Honwana 2002).

During the sixteenth century, Portuguese colonialism expanded into Mozambique but only in the nineteenth Century, after the Berlin Conference, did they launch campaigns for effective occupation within the country. In 1895¹⁰⁶ they defeated and captured the last Nguni King, Ngungunhane, an act that ended the Gaza Empire.

With Portuguese colonialism came white Mozambicans who claimed local ethnic identities such as Ronga and Changane¹⁰⁷. Some of those white Mozambicans with Portuguese ancestry affiliated with local families in the region whether through abuse or consent. Others were assassinated by the natives. Local kin groups now reclaim the spiritual agency of these Portuguese groups in their households kinship.

Portuguese domination was preceded by Persian and Indian mercantile and political migrations into Mozambique. These migrations were associated - among other things – with Indians in Portuguese service, including sepoys in Portuguese India who were later sent to serve in Mozambique.

The racial and social discriminatory legislation *Estatuto de indigenato* (Statute of Indigenous People) and other migratory factors left people of Indian origin scattered across the country, including in rural areas. In Manhiça the businesses, including commercial farms and shops were

¹⁰⁶ Ngungunhana was deported to exile in Açores, Portugal, until the end of his life.

¹⁰⁷ One local important Mozambican political figure from Gaza, amid press reports about his double nationality (Portuguese and Mozambican), once publically claimed that he was a Mozambican from the Machangana ethnic group, and has a perfect linguistic competence of changana language.

run by white Portuguese and 'Indians' (*vabanyana*). In Maputo, *Vabanyana* settled in neighbourhoods within the Municipal district of KaMaxakeni, KaMpumu and KaMabukwana. These neighbourhood, or 'bairros' such as Mafalala, Xiphamanine, Bairro Central and Chamanculo, were populated largely by indigenous *vabanyana* people. Some Mozambican *Vabanyana* became embedded in local social structures and speak Ronga, Changana and Portuguese while others preserved their cast social systems. Those who were acculturated and indigenised called themselves *Varhonga*¹⁰⁸ (Ronga people). The Hindu experience with ancestral spirits and related rituals shaped this history. Some of these Indian descendants (*vabanyana*) remain segregated today and still marry according to their cast systems in Mozambique or marry spouses from neighbouring countries and India. For example, one of my informants who is *mubanyana*¹⁰⁹, and who grew up in Manhiça where his family owns a shop, brought his wife from Kenya while his brother's wife came from India.

All these commercial, political and social processes brought about varieties of social interactions, ties and agreements that led to the social production of new relations between the locals and the ancestral deceased of *vabanyana* and *valungu*. It is in this context that the categories of *xikwembu xa mulungu* (spirit of the white person) and *xikwembu xa mubanyana* (spirit of the Indian) emerged.

Svikwembu sva matlharhi is a category of spirits that does not only refer to a specific ethnicity or nationality of soldiers as some ethnography suggest (see Honwana 2002) but to the spirits of those who were killed in a war. People I studied have experiences with *svikwembu sva matlharhi* from the three wars that happened in Mozambique – the Nguni, the liberation war and the civil war. These spirits encompass *Vanguni*, *Vandau*, some Mozambican ethnic groups such as

¹⁰⁸ During the field work I also engaged with *Vabanyana* from Gaza province who claim belonging to a local main group Changane.

¹⁰⁹ Singular of *vabanyana*

Vachopi, *Vatshwa*, and *Svingondo*¹¹⁰ as well as *Vabanyana* and *Valungu*¹¹¹. *Svikwembu sva matlharhi* are people killed in war by a specific family member. They also designate victims who were killed in a specific community during a war. For example, people killed during the Civil war in Manhiça are claimed *svikwembu sva matlharhi* of the community in rituals conducted by the local traditional leaders. *Svikwembu sva matlharhi* have a very fluid ethnicity because they can be any variety of ancestral spirits. What forms their category is the fact that they died in the context of war or quarrel and seek revenge or social integration in a family or community.

The table below describes the local categories of ancestral spirits, and their relation with local political and economic history. These types make up collective memories and modern identities.

¹¹⁰ *Xingondo* (singular) is a general term used by the locals to refer to ethnicities from the North, especially when they do not know the exact ethnic group of the person/spirit. It was originated right after independence when the first massive national migrations of Mozambicans happened and resulted in placement of Makonde soldiers (typically from Cabo Delgado province) and personnel in the south. In some contexts of Portuguese and for its referents, the term *Xingondo* is derogatory.

¹¹¹ Although I did not have chance to encounter a family with *mulungu xikwembu xa matlharhi* my informants say it exists, and some *tinyanga* say they have encountered it.

Table 3. Categories of ancestral spirits in the South of Mozambique

Category of Spirits	Designation	Origin	Kinship
<i>Vahlonga</i>	<i>Tinguluve</i>	<ul style="list-style-type: none"> • Mother's Lineage • Father's lineage 	<ul style="list-style-type: none"> • <i>Vakokwana</i> (mother's descent group). • <i>Vab'ava</i> (father's descent group). • <i>Vamabhizweni</i> (named after somebody)
<i>Vandau</i>	<i>Svikwembu</i>	Nguni colonialism	<ul style="list-style-type: none"> • <i>Vakon'wana</i> • <i>Vamabhizweni</i>
<i>Vanguni</i>	<i>Svikwembu</i>	Nguni colonialism	<ul style="list-style-type: none"> • <i>Vakon'wana</i> • <i>Vamabhizweni</i>
<i>Valungu</i>	<i>Svikwembu</i>	Portuguese colonialism	<ul style="list-style-type: none"> • <i>Vakokwana</i> • <i>Vakon'wana</i> • <i>Vamabhizweni</i>
<i>Vabanyana</i>	<i>Svikwembu</i>	<ul style="list-style-type: none"> • Asian mercantile diaspora • Portuguese colonialism 	<ul style="list-style-type: none"> • <i>Vakokwana</i> • <i>Vakon'wana</i> • <i>Vamabhizweni</i>
<i>xikwembu xa matlharhi</i> (all ethnicities including the above)	<i>Xikwembu xa matlharhi</i> (spirit of somebody killed in a war)	<ul style="list-style-type: none"> • Nguni war • Mozambique's liberation war • Civil war 	<ul style="list-style-type: none"> • <i>Vakon'wana</i>

The spiritual agents in the table are a reflection of historical events and situations and are fully incorporated in current social kinship structures in which they become part of the family or community and gain identities. The kinship encompasses the establishment of intrinsic family relations between spiritual agents and the living.

Vakokwana is the lineage of a person's mother. *Vab'ava*, which literally means fathers, indicates the relation with a person's father's lineage. *Vakon'wana* means sons-in-law and designates the relation of son-in-law (singular *mukon'wana*). This last relationship is established with all

avenging spirits - of people who seek revenge from those who killed them or owed them goods. They become 'sons-in-law' because in order to integrate them, solve the quarrel with them or heal the misfortune, sickness and impurity caused by their vengeance, families give them an unmarried girl, who becomes the spirit's spouse (*nsati wa svikwembu*), and a boy (whose wife will become *nsati wa svikwembu*). The boy and girl are given to the *vakon'wana* along with a house, domestic animals (generally male and female cows, goats or chicken) for reproduction, and 'paraphernalia' of *capulanas*¹¹² and other specific objects.

The relation of *mabizweni* (singular form of *vamabizweni*, literally *my name* or *named after me*) designates the spirit named after somebody alive and this person reciprocally establishes the same relationship with the spiritual agent. The other local term for this relationship is *mavitokulobze* (plural *vamavitokulobze*). Before Portuguese colonialism, local people were typically named after their deceased ancestors. But because of the assimilation policies local names were regarded too low status since, in order to ascend to "citizenship", individuals also had to embrace a Portuguese name. The strong relationship people had with spiritual agents who played an important role in the construction of identities and harmonious social order is one of the reasons why they continued to use endogenous names. Currently people in my research site and along the rest of the south of Mozambique typically have the 'traditional' name and the official one of 'Portuguese origin'. For example, some of my informants and people I encountered during the research are called João/Madunana, Carlota/Khasilana, Joaquim/Mutema, Elias/Dungane, Flora/Mutukuta, etc. Some names are not exactly the ones that the ancestral spirit had but a recreation of ties and a construction of identities associated with them. Sometimes people do not know the real name of their ancestor because they are from a remote past and so use different strategies to recreate and represent their identity in the living. *Vamabhizweni* are known to protect and guide the living and participate in the formation of their identity.

¹¹² Certain cloth which Mozambicans cover the body from the waist to the knee.

The spiritual agents act through (and as) *tinyanga*. They make a diagnosis¹¹³, evaluate and select treatments, manage and evaluate the therapeutic process, and participate in the formation of identity.

5.1.1.2. The *maziyoni* and *tinyanga*

The community of indigenous medical practitioners in Maputo and Manhica encompass two main groups: the *tinyanga* and the *maziyoni* of the Mozambican Zion Church. The *tinyanga* are subdivided into the *vanyamusoro* (mediums) and the two types of *tinyangarume*¹¹⁴, the *tinyangarume*, who uses indigenous medicines exclusively, and the *tinyangarume (tinyanga)*, who also diagnose with *tinhlolo*¹¹⁵. The *maziyoni* include the *tinyangarume* and the *vapfofeti* (who typically do diagnosis and exorcism). I summarise this in table 4 below. My study focussed on the *tinyanga* because this is the scope of my thesis. The community of *maziyoni* is a relatively different domain of indigenous healing and represents a complex and massive field of study. I will just make a brief description of the *maziyoni* in order to give an overall idea about the way they fit into the local indigenous medicine health practicing.

The Zion Church was founded in the United States of America in Zion, Illinois in 1896. It was introduced to South Africa in 1906 and migrant workers brought it to Mozambique (Comaroff 1998; Cruz e Silva 2002). In Peel's terms, it is more an African indigenous church created by indigenous people rather than being offshoot of other Christian churches (Peel 1968). The Zion Church is an endogenous Mozambican church born in local landscapes and historical dynamics

¹¹³ the diagnosis process is called *kuhlaluva*, and is conducted with the diagnostic tools called *tinhlolo* (see section on diagnosis ahead).

¹¹⁴ *Tinyangarume* is the plural of *nyangarume*.

¹¹⁵ *Tinhlolo* are the diagnostic tools used by *tinyangarume (tinyanga)* and *vanyamusoro* (see section on diagnosis ahead)

in which the historical encounter between indigenous (health practices and) knowledge and Christianity were fashioned in new representations and doctrines (see Hackett 1987; Jules-Rosette 1979).

Some literature associate the Zion church with resistance to the impact of modernization policies; a coping mechanism to address poverty, powerlessness and forms of colonial and postcolonial oppression (See Agadjanian 1999; Comaroff 1998; Comaroff & Comaroff 1999; Cruz e Silva 2001). The idea that there is a correlation between poverty and social exclusion with religious representation; that spiritual healing empowers the urban suffering; and that the *maziyon*i arose functionally from the need to build and integrate social networks jeopardised by social crises and global capitalism is not supported by the practice of these therapists in Mozambique. The experience of global capitalism is indirect that it is locally transformed. Moreover, Mozambicans act according to their knowledge and experiences, social networks, and concepts of belonging and their agency also lies in these factors. Local *maziyon*i representations of health and illness and types of therapist are also intrinsic to the Mozambican fabric that creates the relationship between people and spiritual agents, and in turn the relationship between these agents and their environment.

In relation to the *tinyanga*, previous studies suggest that the different types of *tinyanga* are gendered. Earthy (1933) asserts that the *vanyamusoro* are females and Honwana (2002) argues in a similar vein asserting that the *tinyangarume* are exclusively male. The *tinyanga* I encountered in my fieldwork are “transgendered”. They are distinguished instead in terms of the epistemology underlying their representation of health and sickness; the relationship they have with spiritual agencies; their typical area of health delivery, and types of therapies they deliver (see table 4 below).

The relationship between the *maziyoni* and *tinyanga* in the south of Mozambique has been described as conflictuous, due to competition over the control of patients and territory (see Honwana 2002). Alcinda Honwana asserts that the *tinyanga* and *maziyoni* have very similar ways of representing health, illness and therapy. Both use blood in purification and cleansing, the former using chicken and goat blood and the latter pigeon blood. They also experience spirit possession and use of spiritual agents for healing. What distinguishes them, however, is that the *maziyoni* only accept the spirits from the maternal and paternal lineage (*Vahlonga*, *tinguluve*) in their engagement with the deceased. Alcinda Honwana also reports conversion of former *tinyanga* into *maziyoni* in which their foreigner spirits (*Vandau* and *Vanguni*) are seen as malevolent, rejected and exorcised. Then the *vahlonga* are converted into Mozambican Zion spiritual categories of *mimoya* or *tintsumi*.

The indigenous healthcare providers I encountered throughout my research cooperated more than they clashed. They are also heterogeneous communities of practice. Some *maziyoni* and *tinyanga* have rivalries associated with ethics or the control of patients. The *tinyanga* I interviewed complained that some types of Zion churches steal patients from them. They also denigrated the *Maziyoni* accusing them of using a malevolent technique called *kufula* to kill people as part of their professional practice. These *maziyoni*, on the other hand, blamed the *tinyanga* of accommodating foreigner malevolent spirits. Other groups of *maziyoni* publically denigrated the *tinyanga* but still use their services to enhance social visibility especially with their followers (*kutiyisa xiviri* fortification of the self¹¹⁶). There are also groups of *maziyoni* who are trained in indigenous medicine and practice by *tinyanga* in order to boost their healing skills. The ability of *maziyoni* prophets as 'healers' influences their authority. This is one of the reasons why they cooperate with the *tinyanga* and learn their skill to use in the Church. I witnessed many cases of *maziyoni* conducting therapies akin to the *tinyanga*. The local fabric of indigenous healing by

¹¹⁶ The practice of *kutiyisa xiviri* is outlined in the next section (notion of personhood)

tinyanga is thus continuously shaping the approaches to health, illness and therapy of the *maziyon*. For example, now their *materia medica* for purification is also chicken and goat blood and they also act as mediums with Nguni and Ndau spirits. Certainly some *maziyon* are thus not against foreign spirits in their repertoire in which all available healing agents and agencies are accommodated.

Table 4. Typology of *tinyanga*

Type	Techniques	Function	Category of spirits
Indigenous medicine			
Nyangarume	<ul style="list-style-type: none"> • Observation • Elicitation of narratives • Healing by means of medicinal resources • Counselling 	<ul style="list-style-type: none"> • Therapist • Counsellor 	<ul style="list-style-type: none"> • <i>Vahlonga</i> (from the lineage).
Nyangarume (Nyanga)	<ul style="list-style-type: none"> • Using <i>Tinhlo</i> for diagnosis (<i>Kuhlahluva</i>) • Observation • Healing with medicinal resources & rituals • Counselling 	<ul style="list-style-type: none"> • Therapist • Practitioner of <i>Kuhlahluva</i> • Counsellor 	<ul style="list-style-type: none"> • <i>Vahlonga</i> (from the lineage). • Sometimes (<i>Nguni</i>, <i>Portuguese</i>, <i>Indians</i>)
Nyamusoro	<ul style="list-style-type: none"> • Using <i>Tinhlo</i> for diagnosis (<i>Kuhlahluva</i>) • Observation • Practice of <i>Kufemba</i> (medium & exorcism practice) • Using medicinal resources & rituals to heal • Counselling 	<ul style="list-style-type: none"> • Spirit medium & exorcist (<i>kufemba</i>) • Therapist • Practitioner of <i>Kuhlahluva</i> • Counsellor 	<ul style="list-style-type: none"> • <i>Vahlonga</i> (from the lineage). • <i>Nguni</i> • <i>Ndau</i> • <i>Portuguese</i> • <i>Indians</i>
Zion Church			
Nyangarume (Muzioni)	<ul style="list-style-type: none"> • Using medicinal resources & praying to heal • Observation • Counselling 	<ul style="list-style-type: none"> • Therapist • Counsellor 	<ul style="list-style-type: none"> • <i>Vahlonga</i> (from the lineage). • <i>Holy spirit</i>
Muprofeti	<ul style="list-style-type: none"> • Practice of <i>Kuxokara</i> (exorcism and medium practice) • Healing through praying (sometimes) ritual performance & remedial administration • Counselling 	<ul style="list-style-type: none"> • Exorcism (<i>Kuxokara</i>) • (Sometimes) medium (<i>kuxokara</i>) • (Sometimes) Therapist • Practitioner of <i>Kuprofeta</i> • Counsellor 	<ul style="list-style-type: none"> • <i>Vahlonga</i> (from the lineage). • <i>Holy spirit</i> (<i>moya</i>) • <i>Nguni</i> • <i>Ndau</i>

5.1.1.2.1. The source of *wunyanga* (nyangahood)

Wunyanga (nyangahood) is a gift. The *tinyanga* are chosen by spiritual ancestors to provide health and wellbeing within their society. The spirit agents who lead the choosing process are therapists either because in life they were *tinyanga* or because they have an inherent capacity to heal. A person can also become a *nyanga* because they inherit the different spirits of somebody who, although they were not a *nyanga* themselves, have a capacity as a spirit to reintegrate themselves¹¹⁷ into society with these new functions. These spirits who possess *tinyanga* may be avenging spirits killed by members of the *nyanga*'s family or spirits of the destitute that were given shelter in the family in the past. Some people can be chosen to become *nyanga* by spirits who were *tinyanga*, regardless of whether they had a relative in the past who worked as *nyanga*. These findings are at odds with what has been said in previous literature about the source of *wunyanga*¹¹⁸ (see Honwana 2002; Granjo 2005). These studies report that the *tinyanga*'s spirits are inherited from an ancestral *nyanga* who possesses the candidate in order to become a *nyanga* in the community and continue with their practice. They report that the spirits only target the *tinyangarume* (*nyanga*) and *vanyamusoro* who are already possessed by spirits. But in fact, I found that the ancestral spirits also choose the *tinyangarume* (herbalists) in order to work with remedial healing. The Honwana and Granjo studies also focus on lineage inheritance whilst, in fact, the *tinyanga* are chosen by a number of different types and forms of spiritual agents that may have little or nothing to do with the previous existence of the *wunyanga* in the family. For example, Manuel's *wunyanga*, represented in figure 1 below, was not inherited from any ancestral *nyanga* but entered the family as the avenging spirit of someone killed in the war by his grandparent.

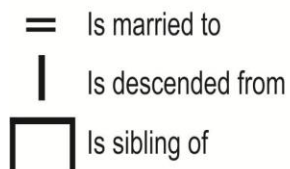
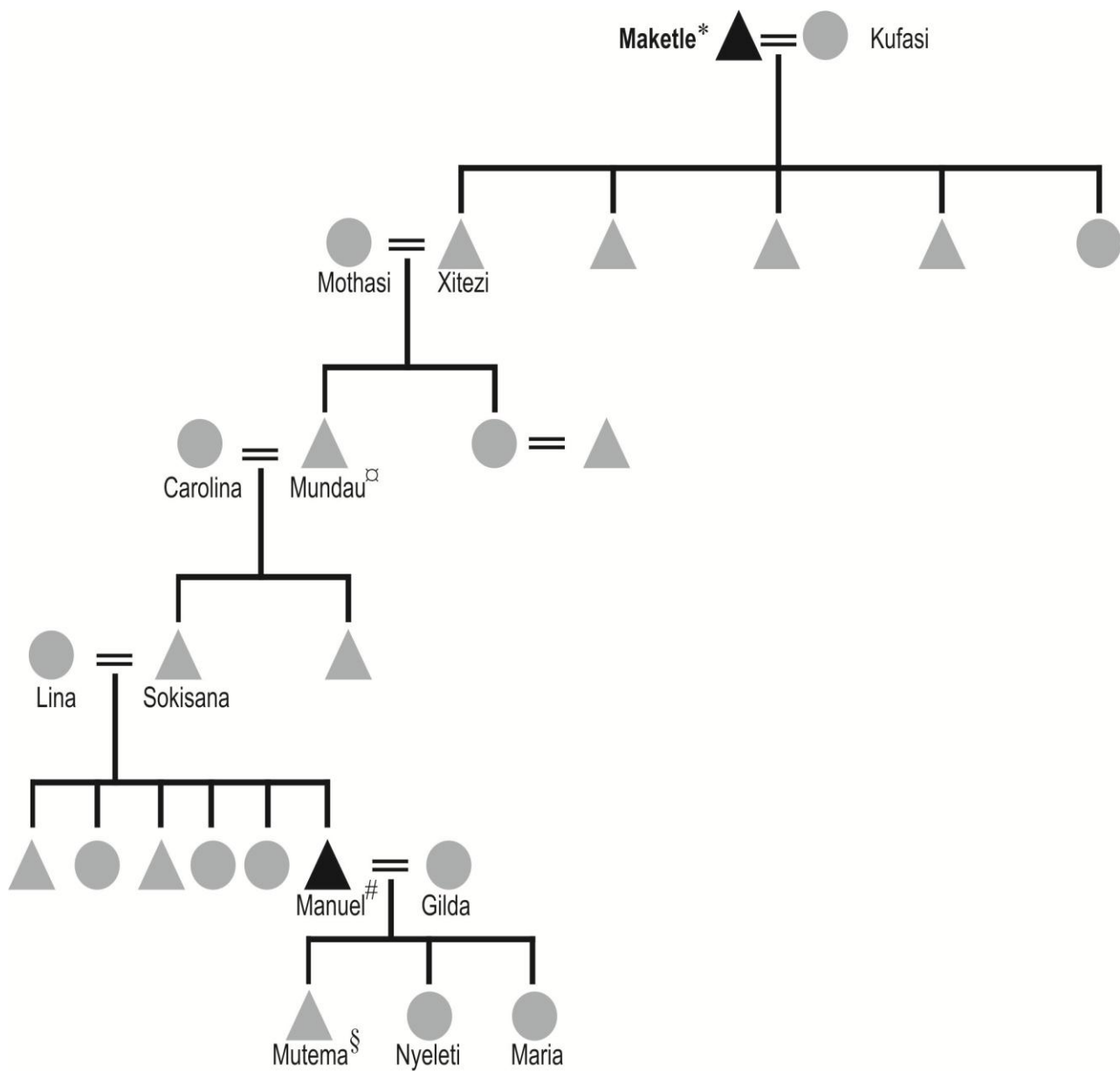
¹¹⁷ Once they are no longer living they come back into society with new functions, this is reintegration, or just integration. It becomes effective if the living 'formally' integrate them through the *mhamba* ceremony.

¹¹⁸ Nyangahood

The common features in all *tinyanga* are: that they are chosen by the spirits (*kulangiwa hi svikwembu*), and that the source of their healing power and knowledge relies on spiritual agents. These spiritual agents are intrinsic to the person's *nyangahood* and transmit the therapeutic knowledge through initiation and/or revelation.

As demonstrated in table 4 the *nyamusoro* professional practice encompasses all the techniques and functions of the *nyangarume* (*nyanga*) and the *nyangarume*. *Nyamusoro* also distinguish themselves from the other types of *tinyanga* by the trance-possession and the *Kufemba* (exorcism and medium practice) with *vandau* spirits.

In order to demonstrate the arguments regarding the source of *nyagahood*, introduced in the first paragraph of this section, I will outline below the genealogies and sources of *wunyanga* of two *vanyamusoro* I worked with in my research.

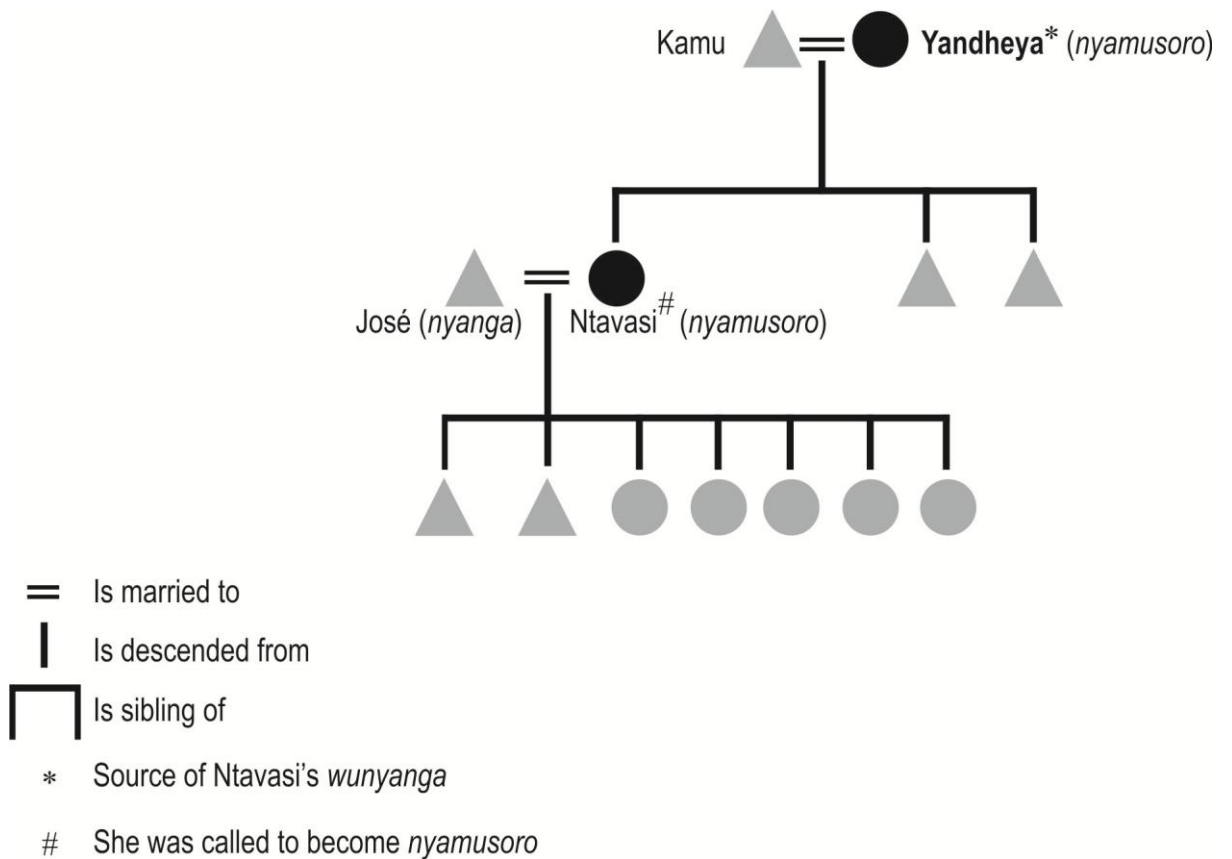
Figure 1. Source of Manuel's *wunyanga*

* He killed a couple of *vandawu* during the *Nguni* war and became the source of Manuel's *wunyanga*

He was called to become *nyamusoro*

□ He was named after the *vandawu* spirits killed by Maketle

§ He was named after the *vandawu* spirits killed by Maketle

Figure 2. Source of Ntavasi's *wunyanga*

All ancestral spirits can potentially possess a person but only some of them are 'elected' to show up (*kuhuma*) in each generation. Every spirit possession has its inherent particularities. However here it is important to distinguish between possession by the spirits who perform intrinsic roles through the *tinyanga*, and possession by those family spirits that use the *nyamusoro* as medium to appear through them (*kuwuma*) in order to communicate with the living. For example, *Ntavasi* is possessed by her mother (Yandheya) because she inherited the *wunyanga* from her but she is also possessed by her grandmother and other kin. Mediumship such as this is one of the most distinctive features and important therapeutic techniques of the *vanyamusoro* and their *vandau* spirits. Through mediumship they also provide the *kufemba* (mediumship and exorcism) practice for particular health seekers and their families.

The *tinyangarume* learn indigenous medicine and healing from ancestors (*vahlonga* only) who show them medicines and/or other healing techniques, including certain rituals¹¹⁹. That is why this sort of *tinyanga* can acquire healing and medical skills without prior initiation or apprenticeship. They can also learn indigenous healing from another *nyangarume*, *nyanga* or *nyamusoro*. The majority of *tinyangarume* I interviewed and know have skills and knowledge to heal between one and four sicknesses only. They are thus specialists in different kinds of illness such as asthma, *xilume*, *xithetho*, *nxanga*, vaginal haemorrhages, and so on (see table 5 on page 164). Therapists of this category are not generally referred to as *tinyanga* or *tinyangarume* at times other than at the moment of recognition of their services with a symbolic payment or souvenir, in which it is made explicit that the patient is thanking the person and (especially) the spirits in order to incite the efficacy of the therapy.

The *tinyangarume* (*nyanga*) by contrast are initiated by somebody who transmits the skills to them through training and apprenticeship. They are trained by other *tinyangarume* (*nyanga*) or *vanyamusoro* in the practice of diagnosis (*kuhlahluva*) and healing with medicinal resources and rituals. Their repertoire of therapies is more diverse than that of the *tinyangarume* and includes 'purification' and cleansing therapies (*kuhlampsa xiviri*), and fortifications (*kutiyisa xiviri*). This category of *tinyanga* is typically chosen by the *vahlonga* spirits but I also worked with some *tinyanga* who work with *vanguni* spirits for diagnosis (*kuhlahluva*) and who use *Vabanyana* (Indian) or *Valungu* (Portuguese) spirits to perform other therapeutic tasks.

In the next sections I will focus on the *nyamusoro* because they are the majority of *tinyanga*¹²⁰ and their educational process includes the fields of knowledge of the other types of *tinyanga*.

¹¹⁹ For example the ritual to heal infertility

¹²⁰ Statistics from Manhiça, Calanga (*Xhau*, *Nsihanini*, *Wusiwanini* and *Xixongi*), shown that *vanyamusoro* represent 82% of the total *tinyanga* (included the *maziyonis*). In Maluana (*Kubomu*) they are 90% (Source PROMETRA)

5.1.1.2.2. Locus of training

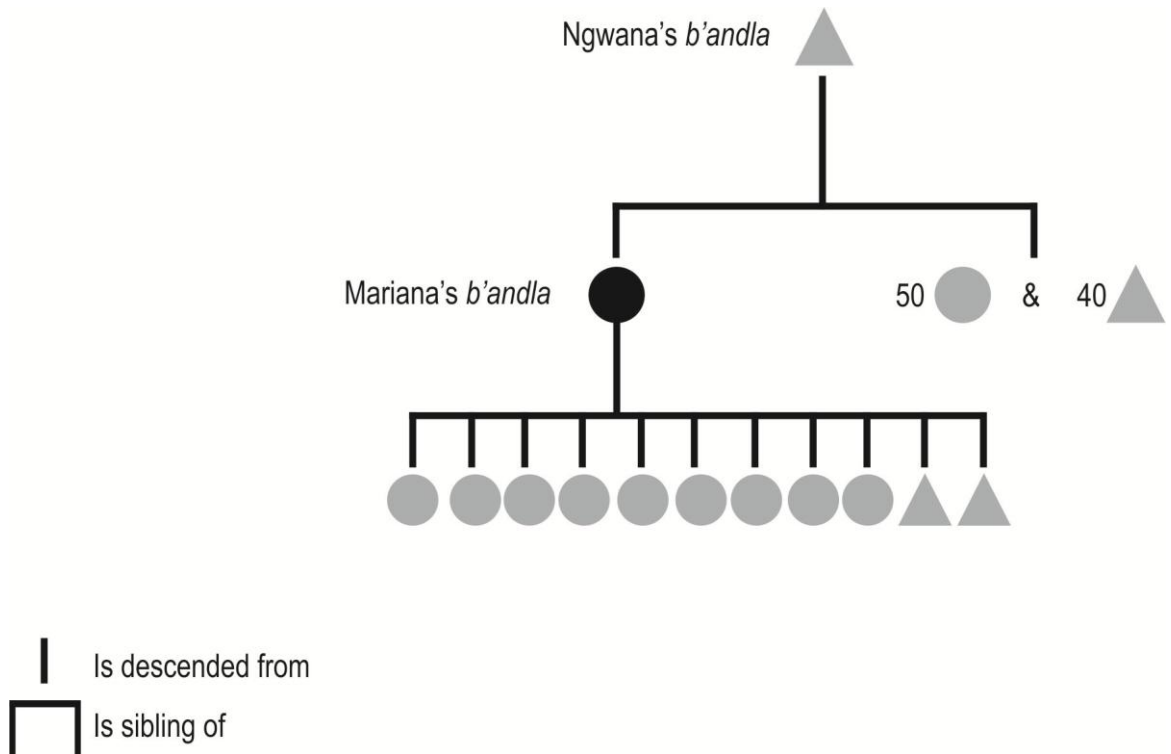
The *tinyanga* are organised into lineages (*mab'andla*)¹²¹ with a senior 'teacher' (*b'ava*) at the top of the hierarchy. The *mab'andla* are based at the household of the *tinyanga* although there is a physical separation between the houses used for the health services and those in which members of the household live. The *b'andla* works and structures itself as a school, and shares and protects the medical knowledge. It is the structure from which principles of good and bad health practices are developed and controlled, and also forms the family of the *tinyanga* from that lineage. The *b'andla* designates the locus of the *nyamusoro* practice and the training of the students (*matwasana*), but mainly the *b'andla* denotes the community of practice of all *tinyanga* from the same lineage. Its structure is akin to that of the normal family in terms of affiliation and intergeneration relations (See fig.3 below). But unlike the normal family the *b'andla* is "transgender" and the common affiliation is based on the locus of apprenticeship and the *b'ava*. Regardless of whether a student is trained to become a *nyangarume* or a *nyangarume* (*nyanga*) she/he is entitled to become a child or grandchild (*n'wana* or *ntukulu*) of the *b'andla*. In this sense the affiliation in the *b'andla* is not based in spirit possession and common initiation as Honwana (2002) suggests. The common initiation and *b'ava* alone are a criterion of belonging to the *b'andla*.

Every *tinyanga* trained in a particular *b'andla* who welcomes new students, becomes *b'ava* regardless of whether they are male or female. *B'ava* (literally parent) is a "transgendered" category. The 'new born' *matwasana* extends the family making it a 'mixed gender descent group'. The medical knowledge is transmitted thorough the *b'andla* down the generations and is typically only shared by the members.

¹²¹ The singular form is *b'andla*.

The ethical conduct of the *tinyanga* is mandated by the *b'andla*. For example, during the counselling of novice *tinyanga* in the integration in professional practice, their *vab'ava*¹²² dictate several rules, such as not using the *wunyanga* to harm people, remaining faithful to the principles of doing good, and respecting seniors and instructors from their *b'andla* and other *mab'andla*.

Figure 3. Mariana's *b'andla*



5.1.1.2.3. *Kuchayeliwa*

The training and apprenticeship in *wunyanga* is called *kuchayeliwa svikwembu* or simply *kuchayeliwa*¹²³. This term is simultaneously used to call the whole training of the spirits and student in possession as well as all other events that sequence the training process (including singing, and drumming, with or without dancing) in which spirits possess the *vanyamusoro*. The *kuchayeliwa* training can be divided into integration and training events and grading and

¹²² Plural of *b'ava*.

¹²³ Generalised from *kuchayela* (to play drums – to incite and accompany the trance-possession), *kuchayeliwa svikwembu* means to be trained to become *nyanga*.

legitimization processes. The integration and training events include the joining process (*kunghena*); initiation of spirits in trance-possession (*kuchayeliwa*); mediumship and exorcism training (*kufemba*); and apprenticeship of diagnosis (*kuthungatha/kuhlahluva*) and treatment (*kudaha*). The grading and legitimization processes includes progressive grading stages called *kudlokisa*; *kuthwasa* and *kuparura*; *kunghenisiwa kwatini*; *kukombela muthimba* and the *muthimba*; and *kulovola svikwembu*. Since my objective in this section is only to outline the socio-cultural agents and agencies in which health and illness are rooted but not to make an in-depth study of the *kuchayeliwa*, I will only describe their integration and training events.

5.1.1.2.3.1. *Kunghena*: response to the calling and integration in the *b'andla*

When people are chosen to become *tinyanga* the spirits essentially find ways to express their will and to turn the person into *nyanga*. People experience it in three categorical ways that include going into trance, suffering misfortune, becoming sick or weak and in pain or having other bodily and social constraints¹²⁴.

Some undergo trance-possession in which the spiritual agent (guest) takes over the body of the chosen (host). The state of the host changes and he/she may, *inter alia*, concomitantly yell, speak in the languages of the guest, fall, shake repeatedly and/or have altered and diffuse states of consciousness. They struggle to control their state but in trance-possession the spirit has the control. This happens unexpectedly and in public contexts such as at school, work, on public transport and the like. It is the most evident way for spirits to express their will and the least contested way among relatives, because despite their ideological orientations, they see that their kin is being controlled by the spiritual agents.

¹²⁴ I would not frame this as *calling "illness"* (Honwana 2002; Granjo 2005, Ngubane 1997) but just *calling by spirits* (which is how the locals call it: *kulangiwa hi svikwembu*).

Those chosen may also have their social esteem and identity weakened, and may not cope with daily activities and social mobility. This is considered a misfortune because other people with inferior or equal abilities perhaps succeed in similar circumstances. It also includes failure where there are otherwise all the social and contextual opportunities for the chosen to have, for instance, a good job, grades or performance.

The chosen may also experience sickness or sicknesses that are healable but where the “healers” from the available medical traditions do not manage to treat them successfully. The illnesses may co-occur or manifest individually but in any of the cases they do not follow commonly known patterns. For instance, it may be *xithetho*¹²⁵ that never heals and has a different smell than usual which distances the chosen from social engagement. It also happens with chosen people that the hospital prescribes and performs blood transfusions for anaemia but the problem persists when it should not in similar circumstances. Other *tinyanga* have complained of persistent body pain, constant vertigo, anal or vaginal haemorrhages and/or skin itching without any therapist managing to solve their problems for a very long time.

Some *tinyanga* have decided to go into training due to social constraints. For example, a significant group of *tinyanga* decide to join because of infertility - but among them are those who managed to have children with the same spouses after they had finished the courses. I saw *matwasana* who before joining the training were reported to have been insane, seeing things that other people could not see such as snakes, scorpions and wall-lizards.

The manifestations above are generally experienced in a context where the chosen host and relatives have the competence to judge what appropriate actions to take. However, they also include cases where people did not really know what to do and others unexpectedly gave them

¹²⁵ *Xithetho* is a type of illness often treated by indigenous medicine that affects the female genital organs. It is described further in table 5.

advise on the actions to take. Local knowledge suggests that in these cases the spirits show that they are also interested in being found as the source of the problem. They may guide the sufferer into social situations involving *tinyanga* as a way of asserting their need to work and may show them the paths to take. In cases where the ancestral calling is through trance, they possess the chosen host (*kumuhumela*) and guide them to find a *b'andla* to ask for their work.

The *tinyanga* diagnose the *calling* from the ancestors. Except in cases of manifestation by means of trance-possession, the acceptance of the calling is not tacit or assumed without questioning. The diagnosis (*kuhlahluva*) is negotiated with the family in complex ways. Some people do not resist accepting the diagnosis, or they recognise it but reject following the will of the ancestors. I have seen many people refusing to accept the *kuchayeliwa* saying that they would prefer to die than undergo the training to practise indigenous medicine. In rural areas or in families with a history of *wunyanga*, people are more receptive to the idea of embracing *wunyanga*. But overall the colonial and postcolonial stigmatisation of *wunyanga* greatly influences the decision about whether to join a *b'andla*. In some cases one wing of a family may decide that the chosen individual should attend the course and others disagree. In a few cases, the chosen host has decided alone to enter the training because the family did not want them to become *tinyanga*. Nevertheless, the *mab'andla* in the south of Mozambique are very active. The number of novice *tinyanga* introduced into the health field increases down the generations, just like the reproductive trends in normal families.

After a person is chosen to become *nyanga* and accepts to follow their *wunyanga*, their kin organise themselves to accompany them to a *b'andla*. Which *b'andla* to go to is usually decided through diagnosis (*kuhlahluva*) by other *tinyanga* and is influenced by the match between the spirits of the chosen trainee and the new *b'ava*. The diagnosis may reveal that the medicines used in a particular *b'andla* suit the spirits of the chosen host. For example, if the spirits of the

chosen trainee lived along a river then they would need medicines from the water (*zunze*) or if the *Nguni* is 'adept in diagnosis' (*kuvona*) they would need a *b'ava* that is strong in that field.

The process of entering the *b'andla* is called *kunghena*. The family comes along with the chosen trainee with the money and the paraphernalia to pay for the *kunghena* of the new *twhasana* (*kunghena* (admission), *twhasana* (trainee)). The amount of money may vary from five to ten thousand *metica's* (one hundred to two hundred pounds sterling) which the *b'ava* divides into two equal parts, for the *Vanguni* and the *Vandawu*. Each type of spirit embodies specific abilities and knowledge in the *b'ava* and *b'andla*. The *Vanguni* do the diagnosis (*kuhlahluva*) and remedial and ritual healing. The *Vandawu* are responsible for *Kufemba* (medium & exorcism practice) and related medicines. The different talents within the *b'andla* of each *nyamusoro* are controlled by the *Vahlonga*, *Valungo* or *Vabanyana* and the *b'andla* is controlled by the *Nguni* and *Ndau* spirits. The *Vahlonga* spirits typically control the *wunyanga* of the *tinyangarume*. The preponderance of spirits and their competence varies among *mab'andla* and this is related to which spirit is essentially the source of *wunyanga*.

At the beginning of the *kunghena*, the money is given to the *Vanguni* and in the *Vandawu* and placed in their *phandze*¹²⁶ which is the main source of power and capabilities of the spirits and used to work and to recruit patients and students (see photo 2 below). The *b'ava* kneels and communicates to both the *Vanguni* and in the *Vandawu* and to their kin about the new student. From this time forth the chosen trainee is known as *thwasana* but called *mutenda* by the *b'ava* which is the term they call the novices until their spirits show up. The *thwasana* then starts a profound process of social transformation by joining the training routines, characterised by abnegation and asceticism. After communication with the spirits (*kuphahla*) the *b'ava*, who in these events is joined by *tinyanga* of the *b'andla*, members of her/his family, and/or other local

¹²⁶ Phandze (plural maphandze), see image below.

novices (*mathwasana*¹²⁷), dictates the rules for the new *thwasana*. One of the first rules is to wash with and eat medicines (*govo* and *nhlambu*) every day except in cases of mourning and other proscribed circumstances. The *govo* and *nhlambu* are the most important medicines of the training in *wunyanga* since they help the spirits to incarnate and control the body of the host, and they help the host incorporate the spirits making them a part of their bodily processes and *wunyanga* (*nyanga*-hood) abilities. They have to use the *capulanas* of the spirits and put on a medical brown powder (*tsumana*) at all times while in training and, in some *mab'andla*, everywhere they go. Other incorporation rules include social codes and modes of address. The *mathwasana* are expected to be happy all the time since it is conceived that the spirits do not align with grumpiness or a "heavy" mood. Initiates have to respond in a particular way (*thokoza*) to everybody who calls or speaks to them regardless of their age and sex. When speaking to seniors and *vab'ava* initiates must kneel down, join their hands with the thumb inside and (usually) look downwards. The *thwasana* is being taught about abnegation - of not being allowed to do what she/he would like - but to do as they are told. Social relationships are cut. They eat what their new family usually eats, and contact with their kin are usually controlled through planned visits. Initiates are required to abstain from sexual relations, alcohol and drugs. Spiritual initiation does not combine with sexual intercourse which is not allowed until the end of the course and the *thwasana*'s professional integration. Intercourse is associated with impurity (*kuhisa*) and sexual flows between lovers jeopardize the process of the combining of the host (initiate) and guest (spiritual agent). It also affects the purity of the *thwasana* and the medicines (*govo* and *nhlambu*) that are eaten and washed with to incite spirit possession.

¹²⁷ *Mathwasana* is the plural of *thwasana*

Photo 1. *Mathwasana* at the initiation course (*kuchayeliwa*)Photo 2. The *Phandze*

5.1.1.2.3.2. *Kuchayeliwa* (initiation of spirits in trance-possession)

Intrinsic to *kuchayeliwa* is the notion of trance-possession. Essentially the spirits chose the *vanyamusoro* and *tinyangarume* (*nyanga*) so that they could possess them. The former is fully controlled by the spirit in trance-possession while the latter only experience partial possession as the *nyangarume* (*nyanga*) do not lose control of their state. It is assumed that the spirits become involved in different degrees during the diagnosis (*kuhlahluva*) and communicate with and through the *tinyanga* the contents of the diagnosis that they share with the patient(s). In this sense the *nyangarume* (*nyanga*) are partially possessed and some even change their individual expressions and characteristics due to the involvement with the spirits. Lambek (1989) argues that trance is the universal model in which people undergo altered states of consciousness

controlled by spiritual agents, whereas possession is the cultural model used to work with the trance and/or deal with the spirits (either exorcising them as in the Pentecostal churches or communicating with them in order to resolve their problems as in the Mozambican indigenous medicine). The process becomes trance-possession because it is both trance and possession. There is no possession without trance and trance cannot exist without possession to represent it according to culturally specific patterns.

In cases where the guest was already being possessed by spirits, the *kuchayeliwa* begins usually the very next day. However, as in the majority of cases people are not called by the spirits through possession, the *kuchayela*¹²⁸ is used to incite the spirits to come (*kuhuma*¹²⁹) working in combination with the *govo* and *nhlambu*. All the main spiritual agents who want to work are called on. In the training events the *Vaguni*, *Vadawu* and *Vahlonga* spirits are called on in this exact order. The host is completely covered with *capulanas* and characteristic music is played with drumming and singing. This process is called *kugajeka*. *Capulanas* are also characteristic of *kuchayeliwa*. Ndaus are usually associated with white and *njeti* capulanas (textiles with characteristic brown and white stripes). The Nguni are linked with the black and red capulanas and cloths with designs of the Nguni shield or animals such as elephants, lions or black mamba snakes. The *Vahlonga* are given white, black, *xisambhi* and *palu* capulanas. *Xisambhi* cloth has white, dark blue, black and red stripes whilst the *palu* have light blue, red and white stripes.¹³⁰ The histories and identities of particular spirits indicate the type of capulana used. The lyrics of the music reflect and shape the idiosyncrasies, historical memories and identities of the

¹²⁸ Event of the initiation of spirits in trance-possession that includes singing and drumming.

¹²⁹ To be possessed is called *kuhumeliwa*.

¹³⁰ See photo 3 below

categories of spirits. They may speak about individual histories of the spirits. Each category of spirits has its own drumming rhythm and musicality.¹³¹

Photo 3. Types of capulanas



The *kuchayela* events involve the *b'ava* and their kin, other novices (*mathwasana*) and neighbours. They are performed early in the morning and at the end of the afternoon sometimes until late. Some people in the neighbourhood play a significant role in the *kuchayela* process. Spirits, even at this early phase, attract attention and are appreciated by those who usually come along to see them. The participants in the possession training (*kugajeka*) play and sing hard and amuse the forthcoming spirits saying for example that they are lazy, that they disturbed the host because they wanted to work but they do not even manage to show up, and that if they are real spirits then they should turn up. In these events, participants also sing and play drums for enjoyment. It is expected that the spirits will gradually possess the host at any time and that the

¹³¹ This indigenous medical music invites new fields of research due to its complexity and for insights that it would bring into disciplines like musicology, literature studies, linguistic anthropology, history, arts and medical anthropology.

process may take anything from a day up to weeks. When the time comes, the host gradually enters a trance, shaking the body which is called *kuboxa misava* (the process of coming from the diseased). When the spirits come it is said *sviboxe misava* (they came from the diseased) and the guest will continuously increase the level of embodiment. After the *b'ava* has evaluated the consistency of the trance-possession the *thwasana* moves on to the next stage.

This process of *kugajeka* - in which the *thwasana* is positioned in particular way and in a particular setting, covered with particular *capulanas* with appropriate musical and discursive genres, and in which the guest spirit manifests itself - is already a trance-possession because it is a form of dealing with the spiritual agent. However, the more significant step is when the spirit of the *thwasana* is taught to 'sit' (*kukhondla*). Each *b'andla* has developed its own way of *kukondlisa* (seating) the *mathwasana*, but the most common one is in a cross legged position. Following this, the *thwasana* may take weeks, or months awaiting the spirits to say their names. The timing that this phase takes depends on a variety of factors including the abilities of the spirits, the permeability of the embodiment process, the physical make up of the host, and the time she/he has been using the medicines *govo* and *nhlambu*.

The first time the spirit talks, it is in the language of the spirits and does not have a planned structure. They just say the name and where they came from. From here on, the host's name is no longer used. The *b'andla* starts calling them by the name of the spirits, generally of the Nguni spirit. They use the name of his *Nguni* spirit because the Nguni conquered the *Ndau* and *Vahlonga* spirits in the past, and their power and fame continues to be reflected in the present. The *b'andla* holds their name partly as a symbol of these historical power relations but also because they were warriors and hunters and this capacity is reflected in their current capacity to diagnose (*kuvona*) and fight against the evil. Using their names gives medical authority to the *b'andla*. This naming represents one of the most significant features of the social transformation of the *thwasana* since in addition to all the other changes they have undergone since entering

their training they now lose a key element of their previous identity. After saying their name and where they came from, the spirits are taught to speak according to the sequential structure of discourse of the *b'andla* which always includes a formal greeting, stating their name and where they came from (if they entered from the mother's or the father's decent), the name of their *b'ava*, their *grandb'ava*, and their *great-grandb'ava*.

The *kuchayeliwa* (initiation of spirits in trance-possession) continues throughout the course, which is why the term also applies to the whole course, which usually takes a year and half to three years in Maputo and between two and five years in Manhica. The timing depends on the dynamics of each *b'andla*, the abilities of the guest and host, the way the host's family engages with the financial demands of the course, and so on. During the length of the course the spirits and the *mathwasana* undergo apprenticeships in different practices that I will describe in the next paragraphs.

5.1.1.2.3.3. The *kufemba* (mediumship and exorcism)

During the *kuchayela*, the Ndaus are themselves trained in *kufemba* which is a technique used for the practise of mediumship and exorcism. The *kufemba* was introduced in the south of Mozambique by Ndaus categories of *tinyanga* and spirits. Local histories and narratives associate the ability to practise mediumship and exorcism (*kufemba*) to Ndaus rituals and medicines which are administrated to children at an early age. It is said that this became intrinsic to their competence. Histories record that Nguni domination brought about the category of *nyamusoro* which came to be possessed by the *Vandawu*, *Vanguni* and *Vahlonga* spirits (Honwana 2002). Table 4 above shows that the current *nyamusoro* also incorporated other spiritual agents such as the spirits of *valungo* and *vabaniyana* that emerged from different political and social processes.

The Ndaus are the only spirits with the capacity, through the *kuchayeliwa*, of becoming mediums between ancestors and their relatives; of exorcising agents, and of catching other spirits

and forcing them to express their will. This way *kufemba* is more complex than the straightforward exorcism that some anthropological literature suggests (Honwana 2002, Granjo 2005; 2006). Paulo Granjo, for example, considers *kufemba* to be amusing and as a kind of 'spectacle', "(...) the most spectacular type of *kufemba* (exorcism) treatments (sic)" (Granjo 2005, p12), which downgrades it and diverts its seriousness for those who practice it. My research subjects do not find the *kufemba* spectacular but therapeutic. The *vanyamusoro* perform the *kufemba* in their compounds and people seek them out not only to exorcise the bad but mostly in order to strategize their health/wellbeing "face-to-face" with their ancestors or with avenging spirits that are jeopardizing their lives.

During the training, the Nda spirit (normally the one who demanded the host work with them), possesses the *thwasana* and exercises the *kufemba* without the instruments that will be used in the practice after graduation. The spirit kneels on all fours and moves around as if harvesting things in the air. This is a rehearsal of real *kufemba* in which the spirit searches for spiritual entities (bad people, spirits and animals) and impurity within the patient holding a little *chovo* (made of hyena hair with a handle fabricated with appropriate medicines) in one hand and in a *xizingo* (a small beaded ring wrapped in cloth with proper medicines) in the other - (see photo 4 below). The search is normally directed to the body of the seated patient(s) and with the *kufemba* potion (*gona*) daubed on them. It is also directed at the physical spaces in the house and at the other patients participating in the event. The entities are 'grabbed' voluntarily or by force, and are either exorcised or the *nyamusoro* becomes their medium. Animals are always exorcised and the *nyamusoro* experience a twofold possession. The *xiviri* of the *nyamusoro* (host) is replaced and she/he is instead possessed by the spirit in action (guest). However, the spirit in action catches animal spirits which do not completely control the host's body. The seized entity is represented in the motion and characteristics of the body-spirit (host-guest) but they are controlled and driven

out by the guest spirit in action. Spirits of both living people (*sviviri*)¹³² and those who are no longer living (ancestors) are caught (*kukhomiwa*) and replace the guest spirit, allowing the patient and other participants the chance to communicate with them. The bad spirits are generally interrogated in order to know their intentions and find solutions for the illness or misfortune. The good spirits are welcomed and household issues are discussed with them, as well as strategies associated with health/wellbeing or the other purposes of the *kufemba*.

Photo 4. *Xizingu* and *Nyamusoro's chovo*



Photo 5. *Nguni Chovo*



Photo 6. The *gona*



¹³² I describe the notion of *xiviri* in the next sections. Basically the living also have spirits that the *kufemba* can seize representing malevolence, hatred, hunger, rancour, etc that jeopardize the norms of sociality and interaction – most of these are normally called ‘witchcraft’.

5.1.1.2.3.4. *Kuhlahluva* and *kudaha* (Diagnosis and healing)

Whilst the Ndau spirits learn and develop their skills in *kufemba*, the Nguni spirits do the *kunyathela* and *kuthungatha*. Of these, the former, *kunyathela*, is a process in which the Nguni spirits possess the *thwasana* every day during the *kuchayela* and move around the *b'andla* with a small lance, and/or other Nguni war instrument, suggesting vigilance and the development of skills to protect the household against witches and undesired spirits. The latter, *kuthungatha*, is the process of learning the diagnostic process that some Nguni spirits perform. It is expected that the spirits develop the abilities to control the host, disclose the problems of the patient(s), and guide them in the restoration of health/wellbeing. These spirits have different capacities, reflected in their abilities to diagnose and power to heal. Only some Nguni spirits have this capacity to diagnose in trance-possession (*kuhlahluva hi svikwembu*). Their skills are a reflection of the *xiviri* that each spirit had in life.

Meanwhile the initiates (*mathwasana*) also learn the *kuhlahluva* (diagnosis), with the diagnostic tools called *tinhlolo* and the *kudaha* (healing) which I describe in the sections concerning diagnosis and therapy below.

5.1.1.3. Medical social structures and kin groups

By medical social structures I mean all the indigenous medical services and institutions that deliver health and wellbeing to the individuals, families and community. They include the traditional authorities and the *tinyanga*. These structures produce and manoeuvre knowledge about health and participate in identity formation and completeness. Traditional authorities and their families have authority in local community rituals and therapies whilst the *tinyanga* (described above) produce knowledge in health and are the local therapists and specialists of indigenous medicine. These social structures are crosscutting factors and play a role in local representation of health and wellbeing, therapy and efficacy. They are modern phenomenon and represent contemporary features of the modern fabric of health.

Local kin groups are descent groups that include clans, lineages, extended families, nuclear families, and single-headed families. Families belong to lineages since they share descent from the same apical ancestor. Knowledgeable members of a lineage can demonstrate and even recite the names of their forebears down the generations from the apical ancestors to the present. Whilst not necessarily accurate, they nevertheless experience it as true and real. The clans do not have such *demonstrated descent* but instead hold a *stipulated descent*. They do not trace their genealogy from the apical ancestor, but just 'believe' that descent to be from the same ancestor or place (see also Kotak's 2000). These clans and lineages control the rituals and community health ceremonies in local chieftaincies according to historically different dynamics and representations¹³³. These include *Regulados* and *Chefias de Terra*. The *Regulados* are ruled by the clans or lineages of the *Régulos* which are local traditional authorities with wider territory under their control and which may have (or not) the more local *Chefes de terra*. For example, the natives of Maluana administrative post say that Maluana is the name given by the Portuguese colonisers that has been adopted by the post-colonial State. The people, however, call this place *Ka Xirindza*, the surname of the lineage of the local traditional authority. They sometimes consider it an administrative post, but this ambiguity is due to the fact that it has a dual administration with, on the one hand the local Queen¹³⁴ who has authority for all cultural issues and community mobilisation. On the other hand, it has a *Chefe do Posto* who represents the state. Other *Regulados* and *Chefias de terra* in Manhiça are not characterised by this co-existence of a traditional chieftaincy and state administrative post over the same territory because the administrative posts encompass a

¹³³ See West 2005 for a detailed account of the construction of chieftaincies and traditional authorities in Mozambique.

¹³⁴ The *Regulo* is a female and the community call her Queen.

number of Regulados and Chefias de Terra which have different forms of influence within their communities. Whilst in Maluana, the Queen is more influential than the *Chefe do Posto*, the same is not true in Manhiça Village and the Administrative posts of Calanga, Xinavane and Ilha Josina Machel that have more than a dozen *Régulos*, each ruling several *Chefes de Terra*. It is not my aim to map the Chieftaincies in Manhiça and Maputo and their relation with the State administration but simply to give a picture of the kin groups and structures in which the traditional powers that control the community healing and efficacy operates. These chiefdoms are controlled by clans and lineages.

Clans and lineages are still usually located in geographic areas in Manhiça as shown in the paragraph above. In Maputo city there are no longer chieftaincies due to social change, massive migration and the power of the modern colonial and postcolonial state that superseded them with municipalities and the apparatus of central government. Clan and lineage ties in the city of Maputo are now claimed and indexed through social networks and identities, geography and sociolinguistic factors. Their role is no longer political but confined to rituals and health practices. In Maputo these groups include the *Mavota*, *Tembe* and *Nhaka* which withstood industrialisation and modern flows and still control the rituals and health practices related to their communities. For example, the *Mavota* family headed the resolution of the *Quisse Mavota* case reported in chapter IV, in which students from the Quisse Mavota School experienced spirit possession. They, along with the community and the *tinyanga*, supported by the Maputo Government, had used indigenous medicine therapies to solve the problem.

People claim to belong to clans and ethnicities using a variety of strategies. Geographically, they use administrative frontiers and regions to claim social ties. The *Xirindza* lineage in Maputo would claim to belong to Maluana. If one's surname is *Khosa* one would be asked if it is *Khosa Ripanga* or *Khosa Tuvuye*. The former is typically from Magude district and

surroundings, northwest of Manhiça which implies Changane ethnicity, and the later is from Manhiça and claims the Ronga ethnicity. The ethnic and clan ties are not static but fluid. Secondly, some people claim to belong to a certain ethnicity because their parents are also from that group. If their parents are from different groups people may claim to belong to both according to the interests and advantages each has. In Manhiça I found people who argued that their children were Ronga because they were born and grew up there. This associates the sense of group belonging to the region of socialisation. These identity claims create affinities and affiliations which contribute to the formation and nature of the therapeutic landscapes, the construction of the *mab'andla* where the *tinyanga* are trained, and in the decisions that people make in order to choose their therapy.

The families in Southern Mozambique are typically exogamous and the descent is patrilineal. This means that people marry outside their groups and join the group of the husband. The idea of “same blood” is build up through male descent. Even if the children are raised among their mother’s lineage (*ka vakokwana*) or by the mother herself, they grow up with the father’s name, unless it is not known. I found some rare exceptions in which mothers attribute their descent name to their children but these variations are modern. In local endogenous practice women, if they get married, do not lose their surname although they move to the husband’s lineage. Those who change their name in official documents, whether completely or put alongside the husband’s surname are still called by the surnames of their lineage in local cultural interactions and in indigenous health practices .

The lineages of the traditional authorities play a significant role in therapeutic strategies and influence decisions about therapies. They are the locus of illness and efficacy in the therapies performed in the communities. The families also play important roles and do not just take charge of therapy management with or on behalf of the sufferer (Jansen 1978b)

but very often they constitute the model and locus of therapy and efficacy themselves, as we will see later.

5.1.2. Local notion of personhood

The second essential element in the local fabric of health and illness is the notion of personhood and the related underlying categories. What does it mean to be a person in Maputo and Manhica? An understanding of the person entails two main dimensions with internal subdivisions. I will now present some levels of these subdivisions.

5.1.2.1. The human body

The first important dimension in the understanding of 'personhood' is related to the notion of the human body. There are two main views of the human body in the health field in Mozambique. One is associated with biological sciences and is transmitted through formal education in schools. This knowledge is typically represented with the discourse of Portuguese language and is possessed by people with competent formal education¹³⁵. Another type of knowledge is framed within indigenous epistemology and is acculturated by means of socialisation. Both people with formal education and those without instruction have command of this knowledge. Young people without linguistic competence in Bantu languages however, do not have good competence of these indigenous epistemologies¹³⁶. I did not see any correlation, in either group, between these types of knowledge and health seeking. People seek therapy in both indigenous medicine and biomedical health services regardless of the kind of knowledge or repertoire of knowledge that they have. Also, social practices are not necessarily associated with competent knowledge in either case, because the majority of people either have no competent knowledge or hold

¹³⁵ These people represent approximately 25% of Mozambicans.

¹³⁶ The colonial assimilation policies and postcolonial linguistic planning only promoted Portuguese into official discourse. As shown in chapter IV indigenous knowledge was also excluded from official domains. This incited the emergence of monolinguals educated with scholarly biological views of the human body.

fragmented knowledge about the human body, the biological notions in particular. The health specialists of both available medical traditions are the ones who have significant knowledge about the human body and health.

The biological notion of the human body is associated with biomedicine health, illness and therapy. This view prescribes an opposition between spirit and matter, mind and body according to the principles of the philosopher-mathematician Rene Descartes. The study and representation of biomedicine lies on the analysis of the physical body made up of organ systems, tissues and cells. This biological organic system is represented in local health delivery in all hospitals in Mozambique. Indigenous notions of the human body, on the other hand, are based on a different knowledge of illness, with the *tinyanga* being the gatekeeper to that knowledge. I will dedicate this next section to the indigenous notions of the human body held by the *tinyanga* in my research site: A human is divided into three main components, the blood (*Ngati*), the physical parts of the body (*svirhu*), and the spirit (*xiviri*). These three elements form the body as a bound entity and work together to make it function in all states of wellbeing, health and sickness. They are interconnected so the following divisions are just for heuristic analytical proposes.

Ngati really refers to body fluids. These fluids encompass the good, useful fluids and the bad, harmful ones. The first set of *ngati* covers what in systemic biology and English language is known as blood (generally just called *ngati*), but extends to the sexual fluids; vaginal fluids (*ngati ya xisati*) and sperm (*ngati ya xinuna*), and the saliva (*marhi*), and the mother's milk (*mafi*). The second group of *ngati* indicates bodily category of sicknesses or the category of bad blood associated to a specific sickness. This typology can include for example *ngati ya xikandzamehi* (gonorrhoea) literally gonorrhoea's blood, *ngati ya malariya* (malaria), and *ngati ya ndhapsha* (a type of indigenous medical sickness). A good example is also given by one of my informants who during my field work went sick and I went to visit her at the ophthalmology ward, where she was hospitalised due to problems in her eyes. She asked us not to worry because:

“It is a temporary sicknesses (*moya*), and will pass away (...) the hospital is bursting with sufferers of this sickness, this *ngati ya matihlu* (disease of the eyes)¹³⁷, it's everywhere, (...) the hospital may struggle to cope.”/ “(...) *I moya, wutakhaluta (...) axipiritana hinkwaku ketala hi va ngati leyi, angati ya matihlu i yinyingi (...) axipiritana ketala ha yone, xitatshika xingavakoti vanhu.*”– Carolina Machele, from Manhiça

Local knowledge of the human body and health stresses that *ngati* works to balance, to vitalise, to run or flow thorough the body and protect it from sickness. *Ngati ya xisati* and *ngati ya xinuna* (sexual fluids) participate in the reproduction, lubrication and growing of other similar bodies. The *marhi* (saliva) protects and lubricates the body. Finally the *mafi* (mother's milk) nourishes similar bodies and protects.

The second main division of the human body is built up by *svirhu* (parts of the body). The *svirhu* are both (1) internal organs and (2) external body. The former include the *mbilu* (heart); *xivindzi* (liver); *yinsu* (kidney); and the latter, the *nhloko* (head); *nkolo* (neck) *mavoko* (arms); *minenge* (legs) and *nhlana* (trunk). These elements are subdivided according to local ethnobiology which in many cases classifies them differently from the systemic (ethno)biology taught in schools. Organs and body divisions have mechanical, protective functions.

The third and last of the interrelated dimensions of the body is the *xiviri* which is the spirit/soul. *Xiviri* is not the body but the individual spirit that makes one alive and forms the self that is projected socially. It is a concatenation of the state of being alive, the individual aura, and the dynamic projection of the self.

¹³⁷ Note that some conditions of the eyes have a sub-typology. For example, the cataract is known as *nxanga*.

The following passage explains better why the *xiviri* represents the state of being alive and is constitutive part of life and health:

“(...) when you get sick, your *xiviri* gets parted from your body (...) depending on the type of illness, if the sickness is really killing you, it slowly leaves the body (...) then you see that *axiviri xa lweyi xofamnba* / this persons *xiviri* is leaving (the body). *Langusa mbabzi ya malaria, yisungula kubahla loko murhi wutirha, axiviri xibuya* (...) / the malaria’s patient starts sweating when the medicine works and the *xiviri* rejoins the body again. If the sickness *ali moya* / is transitory the *xiviri* does not suffer, it is just you physical body that suffers (...)” – (Obadias, *nyanga* member of the participation group in Manhiça).

Xiviri represents life because when it is displaced or being displaced from the body it means that one is dead or dying. It is a constitutive part of life and health because it alone does not make up the living and healthy person. Instead, in a healthy person the *xiviri*, *svirhu* and *ngati* are intertwined and build up the human body that together makes a living person. Different imbalances in people’s condition can influence the connection of the *xiviri* to the physical body. The way the *xiviri* is tightly connected and interdependent with the physical body (*svirhu* and *ngati*) suggests that the human body is a body–spirit.

Xiviri is concomitantly individual aura since people are known to leave trances of their *xiviri* in their daily activities and motion. For example, it is said that the dogs can follow people because these animals have the capacity to sense and see every individual *xiviri*. As Jonas, a *twasana*¹³⁸ who I worked with in Maluana said when we lost the sight of the dog that came along while harvesting medicines: “The dog cannot get lost because it can scent our *sviviri/ Ambzana ahingelahleki hikusa yasvikota kulandza sviviri svahina* (...)”. In this local view ones identity is projected through the *xiviri* which also marks the individual identification.

¹³⁸ ‘Student of indigenous medicine.

The *Xiviri* is also a dynamic projection of the self because, besides the fact that it identifies people, it projects this self to the fellow citizens through the *xithuzi* (identity, self, presence). The embodiment of *xiviri* is one of the features of a living person and the *xithuzi* is the embodiment of the social in *xiviri*. For example, individuals such as Jonas or Maria, a police officer, the local queen or the *nyanga* all have their own *xiviri* and project their particular *xithuzi*. People undergo therapies called *kutiyisa xiviri* (fortification of the *xiviri*) and *kupfuxeta xiviri* (upgrade of the *xiviri*) each and every time they change their social status. For example, when an inspector is promoted into superintendent there is the public ceremony in which the General Commander of the police or the President as Commander in chief grants the rank but those officials afterwards usually go to the *tinyanga* in order to perform the *kutiyisa xiviri* and *kupfuxeta xiviri*. In this situation the two therapies are mutually dependent: the former is to create self confidence and protect against bad intentions by fellows and misfortune. The later upgrades the *xiviri*. The public servants exemplified here are given new offices by their superior but go to indigenous medicine to change their “bodies” into the new *sviviri* that project their new social personalities. The relationship between the body and the *xiviri* is interdependent. That is why it has to be fortified and upgraded every time the body changes its social identity, status and social spaces.

The *tinyanga* recommend to their patients that this treatment is repeated after two to three years. Some patients I observed in these therapies said that they returned to conduct the *kupfuxeta xiviri* because they felt they needed to, because:

“My presence and the way I feel myself tells me that I am not complete (...) It is important that I have the *xiviri* and personality of chief” – Informant from Maputo/ “(...) *lesvi vanivonisaka svona, ni lesvi nititwisaka svona svanibzela svaku anitlhangananga (...) kulaveka nini xiviri xa xefe (...)*”

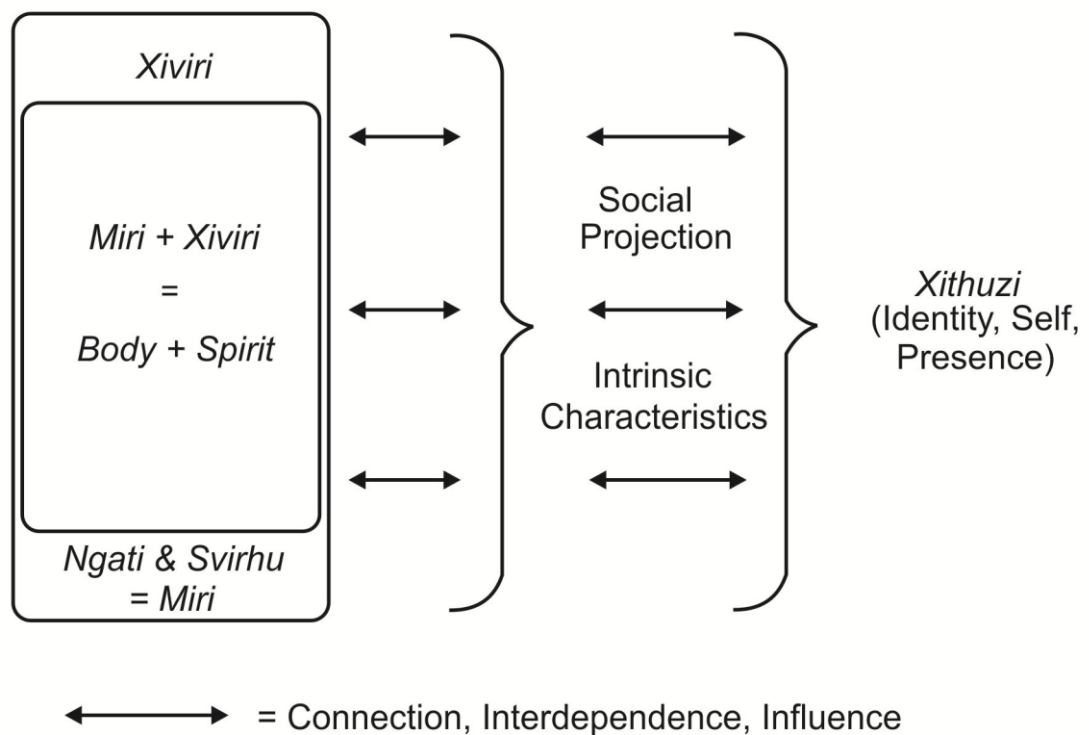
This implies that the *xiviri* is mutable, and changes over time amid the changes of one’s social status, and that it has to be continuously reshaped, which means that persons themselves are not

definitive but in constant construction as well. The relationship between the body and the *xiviri* is therefore in constant construction and there is never a definitive outcome.

The different elements of the human body are interconnected and build up a whole body-spirit.

The representation of this body-spirit would be as follows:

Figure 4. Preliminari representation of personhood – The human body



5.1.2.2. Social relations

The second important dimension in the understanding of personhood is related to the social relationships that people establish between themselves. Personhood depends on the relationships that people establish with the community, their kin and their deceased ancestors. The relationship between people and these three social institutions are taken seriously in one's social existence. For example, people in a better social position and job or with assets have the responsibility to take care of their kin in underprivileged positions. Most diagnoses of hatred or

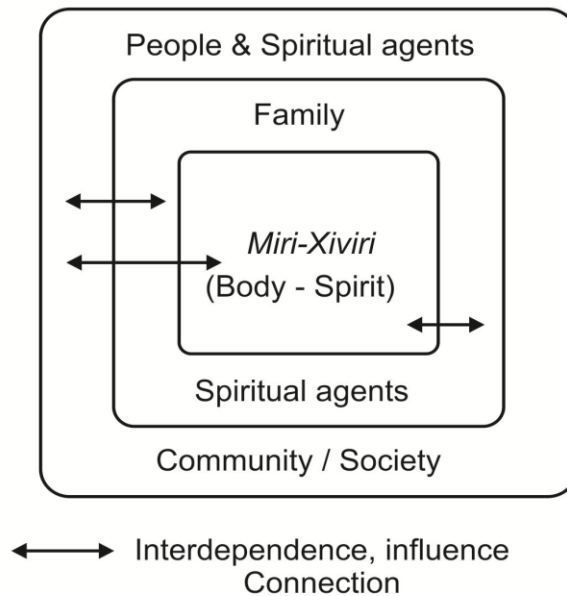
witchcraft made by the *tinyanga* and said to result in misfortune derive from people not complying with this social responsibility that is conceived to establish harmony and balance. Ties and harmony between people in the family and community are very important in order to establish sociality, to build the body-spirit and to project the identity.

Local people typically give up their first salary to the parents or to those who raised them and to the deceased ancestors through an oral communication with them (*the kuphahla*). This gesture is meant to propitiate the good fortune, show appreciation and direct the flow of income to the wider personhood that exists beyond the person. If one fails to do this, the parents show grief and the involvement of the spirits in the propitiation of good fortune and protection may be withdrawn. Hence the person becomes incomplete.

Parents have to take care of their children and children have to take care of their parents when they get old. The 'western' idea shared by a Finnish friend of mine, who visited me during my fieldwork, that her parents were in a home for the elderly, astonished my research participants because in their culture the kin has the responsibility of taking care of each other. They said that their parents are part of their identity so displacing them from family would jeopardize the completeness of their personhood.

Living people are dependent on their ancestors. They communicate with them regularly, provide them with paraphernalia which they also use in ceremonies and to represent their existence, and name their children after them. The deceased ancestors protect, provide health and participate in identity formation of the living and those named after them. The final representation of personhood is as follows:

Figure 5. Final representation of personhood – Human body and Social relations



As is represented above, the association between the human body and the social relations makes the personhood relational and dividual. It is relational because the body - spirit (*miri* and *xiviri*) are interconnected, interdependent and equally important for the existence, day-to-day living and construction of the identity of individual. This concatenation in turn becomes effective if its relationship with the community, the family and the ancestral spirits is 'harmonious'. It is dividual because the relationships and the bond they have among themselves at the level of body-spirit and social interactions is continuously shared, composed and extended through other persons in social existence, practice and experience.

The dividual and relational nature is controlled and regulated by the principles of harmony, commitment and influence between people and their community, the family and the ancestral spirits. As Pool & Geissler (2005) would point out, the dividuality and relationality regulate social identity and existential formation. This representation and praxis produces and informs

how people build up knowledge, experience and practise their relationship with the environment, their bodies, health, sickness and therapy. In the next section I address this knowledge, experience and practice.

5.2. Illnesses, diagnosis and therapy

5.2.1. Illnesses

Indigenous categories of illness reflect types of conditions and actions that can provoke ailments not just in the human body (body-spirit), but also in the family or community or indeed across these three levels. Illness can then threaten the human body (body-spirit), the family or the community. Local categories of illness reflect harm, dysfunction or disharmony within these elements, which are represented through bodies, relationships and social spaces. In this context, the main causes of sickness are the ancestors, being around death and bloodshed, being in other impure settings, social disharmony and social problems, ill will of other people, and *tingati* (environmental agents and infections). These aetiologies of sickness can sometimes provoke different isolated sicknesses in people but, in other cases, these sicknesses can occur simultaneously as they are interrelated and may act interconnectedly.

Spiritual agents of ancestors can cause sicknesses of any kind in the body-spirit or in its separate parts. They can also provoke spirit possession, when they take control of the host body and use it to express their agency or perform therapies, or spiritual involvement, when they influence the actions and activities of any individual without possession. When people die, they need social reintegration in order to join the households and perform and perpetuate their agency¹³⁹. The

¹³⁹ Spiritual agents are reintegrated in a ceremony called *mhamba*. The 'house' where they are hosted is called *ndhombha*. *Ndhombha* does not indicate the physical house only but also the paraphernalia and all other symbolism associated to the presence of the ancestors in the 'house'. The paraphernalia of the *tinguluve* (patrilineal and matrilineal spirits, *vahlonga*) are essentially *capulanas*. That of the *svikwembu* (*Nguni*, *Ndau*, *Valungu* and *Vabaniyana*) includes a diversity of *capulanas* and different kinds of spears.

deceased ancestors can provoke harm if the living do not cleanse and reintegrate them back to society after death or do not follow their social wishes. Once they are deceased, they also become impure with the death (*ntima*) along with their family or lineage (people and the social spaces they inhabit). This is why they have to be cleansed. *Ntima* is the condition that emerges when somebody dies. It is also produced in some social circumstances such as the exposure to bloodshed in war (for example the soldiers, those who kill or are exposed to killing). These settings are known to be impure with *ntima* which is then harmful to the human body-spirit and surroundings. *Ntima* is associated with death-related impurity which provokes social restriction, misfortune, depression and/or trauma. The spirits are not voluntary producers of *ntima* but involuntary and indirect victims. It is their death or the context of their death that provokes it and harms them as well. This condition is a mechanism to propitiate social reintegration of the deceased ancestors; mourning; social reintegration of the living relatives; social reintegration and forgiveness of those exposed to bloodshed; social purity; social visibility and self esteem.

Ntima is related to another condition called *xisila* that denotes social impurity related to socially “restricted” places or that may have *ntima*, such as cemeteries, mortuaries, jails and incarceration cells. *Xisila* can also be caused by spiritual agents when they demand something. The relationship between *ntima* and *xisila* is similar because each is associated with specific places and social situations. The former implies the latter but the opposite is not necessary true. A person may have *xisila* without having *ntima* but if is exposed to *ntima*, they will necessarily also have *xisila*. The healing of *xisila* propitiates social purity and reintegration, and social visibility and self esteem.

Social problems and disharmony are also the cause of illness in indigenous medicine. In some of the diagnosis (*kuhlahluva*) I observed problems in the bodies of the patients, such as those

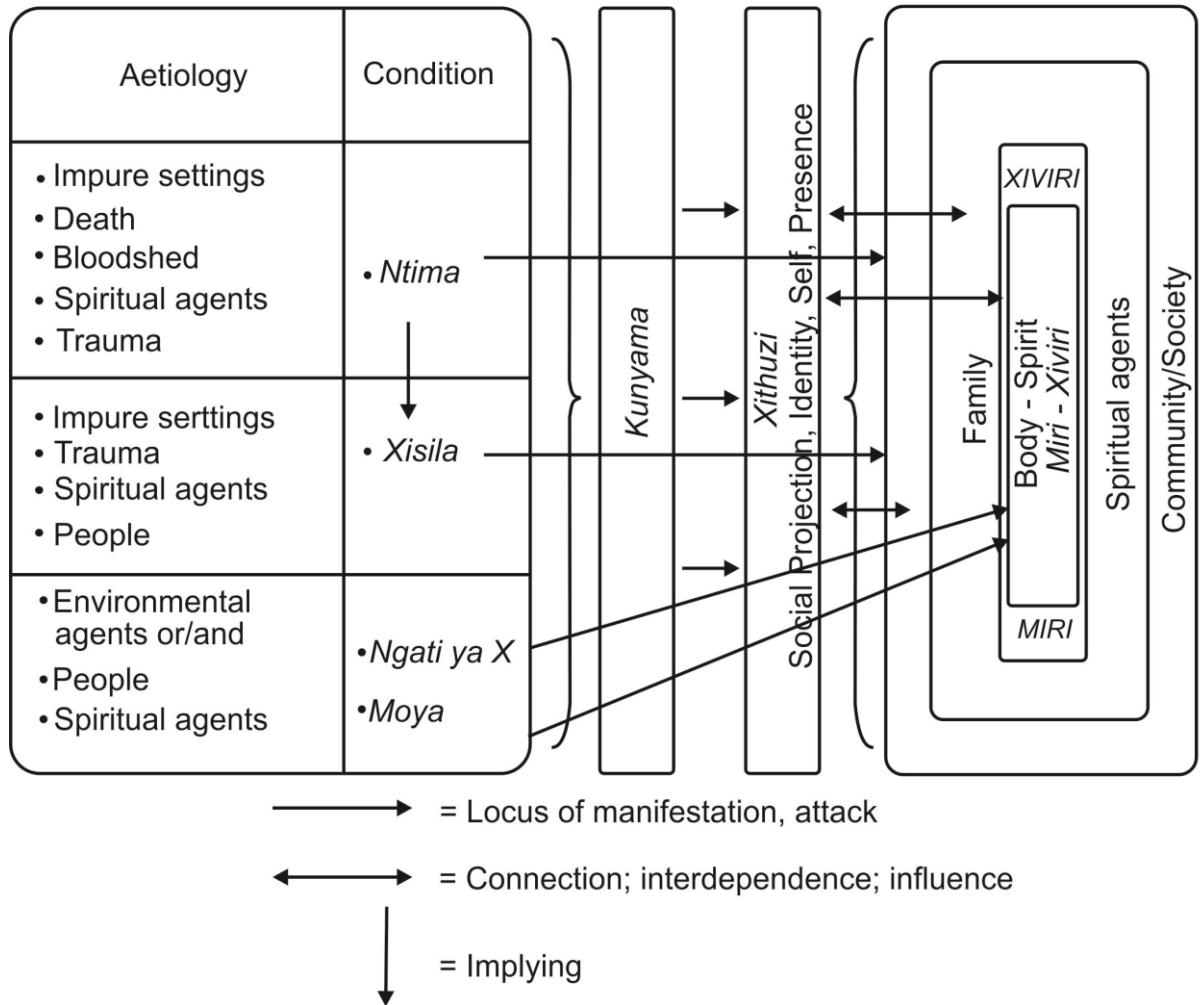
related to the heart and lack of emotional stability, were linked to financial difficulties, lack of job, marital problems, anti-social children, etc.

People are known to harm others through *wuloyi* (witchcraft); a word which comes to connote enmity, jealousy or rancour. People with these feelings are represented in local therapeutic processes as beings with a capacity to cause harm or social disharmony and discomfort. Their agency to harm does not lie on their capacity to fly at night and eat people, as Evans-Pritchard (1937) describes in '*Witchcraft, Oracles and Magic among the Azande*' or as Junod (1996[1912]) describes in his writings on witchcraft among the southerners of Mozambique. *Wuloyi* is a representation of their feelings and anti-social behaviour and of the mechanisms to solve this. It is not magical or occult interpretations of behaviour, with forms of metamorphosis into lions, or an "invisible realm" (as opposed to the visible, rational and measurable western realm), nor is it resistance to modernity or even a discourse to overturn political reforms, as some literature argues (Ashforth 2001; West 2005). Why are there such magical interpretations? For whom is witchcraft occult and magical? The majority of the literature on African 'witchcraft' and 'occult' does not define what they mean by those words? A more contemporary anthropological review is now needed, where the analysis of witchcraft in Mozambique is made in the field, using the perspectives and linguistic competence of those who experience it.

Finally, the human body (body-spirit) can become sick or develop a condition due to *tingati* (environmental agents and infections). The *tingati* are kinds of bad blood which are associated to *svitsongwatsongwana* (environmental agents or microorganisms; *bacterias*, *microbes*, *germs*) and *moya* (environmental and social 'pollution'), all of which can provoke illness in the human body.

The representation of illness in relation to aetiology and the web of the internal and external relations would be as follows:

Figure 6. Illness representation in relation to aetiology and personhood



The schema above represents sicknesses in relation to aetiologies and webs of relations. It shows that there are three main classes of conditions (*ntima*, *xisila* and *ngati* or *mavabzi ya x*) which are caused by different factors named above and attack different loci. This division of conditions is not based on hierarchy but on type and nature. *Ntima* and *xisila* are conditions that 'attack' the body-spirit, the family and community/society in different degrees. At all levels they can provoke *kunyama* which is the reduction of the compulsion or trauma of the social projection, identity, self

and presence (*xithuzi*). The family and community have their intrinsic social projection and identity (*xithuzi*). People have *xiviri* (spirit) and *miri* (physical body), and both project the *xithuzi*. When a person's *xiviri* or *miri* or both, and the family/community *xithuzi* are attacked by the causes listed in the first column of the schema, this may lead to *kunyama* and would affect their *Xithuzi*. In the body-spirit *ntima* and *xisila* can also lead people to expose themselves to or become vulnerable to several conditions associated with environmental agents and infections (*ngati ya x; moya*¹⁴⁰).

The *ngati ya x*, and *moya* are sicknesses and conditions that attack the human body (*miri*) in the 'blood' (*Ngati*) and parts of the body (*svirhu*), or in both body-spirit (*miri* and *xiviri*). An example of an illness targeting the *miri* would be *ngati ya gonorrhoea* (gonorrhoea); or *ngati ya malaria* (a mild/early stage of malaria). Other causes that can attack the *miri* without jeopardizing the all body-spirit are wounds or hearing problems, headaches, flu, coughs that do not last for long or are not very traumatic. The latter stages of long-lasting or traumatic sicknesses may lead to *xisila* and *kunyama* because the sufferer becomes shocked, traumatised and socially restricted. Their *xiviri* (and *xithuzi*) get parted gradually or unlinked to the *miri*. This process is subject to the state of the person at the time and all influences the evaluation made by the *nyanga* or attentive observer. The sicknesses in the body-spirit are a continuing process in which severity, stage and timing determine the degree, level and location of harm.

In the table below I present an indigenous medical typology of illness. The purpose here is not to present all indigenous types of sicknesses because that requires a different type of study. I also believe that future applied work will improve this classification. It is just to demonstrate some common ailments and their categorisation.

¹⁴⁰ For example *moya wa mukhuhlwana*/ flu; cough. They are environmental transitory conditions, not exactly sickness.

Table 5. Typology of illnesses of indigenous medicine: classification in terms of people's age and gender

Sickness	Representation	Aetiology	Gender
Group sufferers			
Women (W), Men (M) and Children (C)			
<i>Wheti</i> or <i>nyokana</i> (a kind of epilepsy)	Convulsions, abrupt falling, modification of eye colour and state, unconsciousness, etc. In Children: severe diarrhoea, fever and convulsions, etc.	<ul style="list-style-type: none"> <i>Nyokana</i> (a kind of bodily agent) 	Neutral W, M, C
<i>Xikandzamehil</i> / Gonorrhoea	Pain, burning and pus in the genitals especially in urination and discharge, in women vaginal discharge and pelvic pain.	<ul style="list-style-type: none"> Bodily microorganism (<i>ngati</i>) which creates related nucleus (<i>rhanga</i>) in the genitals and reproductive organs; <i>ngati ya Xikandzamehil</i>/ Gonorrhoea blood. 	Neutral W, M, C
<i>Ntima</i> (death related social impurity)	<p>Social restriction and rejection; misfortune; depression, traumatic stress, post-traumatic stress disorder.</p> <p>Collective or individual lack of will; (<i>kunyama</i>) absence of <i>xithuzi</i>; Being disliked or developing enmity regularly with no apparent or objective reasons.</p>	<ul style="list-style-type: none"> Lack of remedial and/or spiritual purification after the death of a relative or demobilization/return from the army/war setting; Contact with social impure environment, bloodshed. A Kind of sorcery/ <i>wuloyi</i> (<i>kutekiwa xiviri</i>/ be taken <i>xiviri</i> away) Ancestors 	Neutral W, M, C
<i>Xisila</i>	<p>Social rejection; misfortune; depression, traumatic stress.</p> <p>Collective or individual lack of will; (<i>kunyama</i>) absence of <i>xithuzi</i>; Being disliked or developing enmity regularly with no apparent or objective reasons.</p>	<ul style="list-style-type: none"> Lack of remedial after an exposition to a impure setting; Contact with social impure environment. Stigma Socially traumatic event Ancestors 	Neutral W, M, C
Malaria	Headache, muscles pain, fever and lack of appetite.	<ul style="list-style-type: none"> Mosquito Dust 	Neutral W, M, C
<i>Kuwoma tlhelo</i> (Thrombosis)	Severe headache, heat in one side of the body, side located paralysis.	<ul style="list-style-type: none"> Stress Social problems (<i>kutshama uvavisekile</i>) Or Witchcraft (<i>kuthakiwa</i>) 	Neutral
<i>Kutshamiwa</i>	<p><i>Munyama</i>¹⁴¹ with specific signs in the body (mainly in the genital area, anus, face and back).</p> <p>People may inherit from the kin, it but is healable. It causes</p>	<ul style="list-style-type: none"> Social end bodily impurity Or Spirits (spiritual involvement) Or Possessing spirits Congenital 	Neutral W, M, C

¹⁴¹ *Munyama* is the noun for *kunyama*. *Kunyama* is a state of being, a process.

Sickness	Representation	Aetiology	Gender
	misfortune and individual lack of will. In women it provokes abortions.		
<i>Kukala ngati</i> (anaemia)	Lack of blood, skin whiteness, weakness, long bodily pain and sickness.	<ul style="list-style-type: none"> Physical disorder (<i>kukala kumbe kuhoneka nkati</i>) 	Neutral W, M, C
<i>Nkohlela</i> (something similar to tuberculosis)	Severe and long lasting cough, fever, night sweats, thinning and weight loss.	<ul style="list-style-type: none"> Bodily Microbe. Sex before purification and social reintegration. 	<i>Nkohlela ra mpsele</i> (female <i>Nkohlela</i>) <i>Nkohlela ra duna</i> (male <i>Nkohlela</i>) W, M, C
<i>SIDA (AIDS)</i> ¹⁴²	Long lasting cough, thinning, whiteness, night sweating; different sicknesses (<i>tingati tinyingi</i>). <i>Treatable Tingati</i> resisting to treatment.	<ul style="list-style-type: none"> <i>Ngati lompfanyi</i> (chameleon blood)¹⁴³ Unknown <i>Xitsongwatsongwana</i> (microorganism) 	Unknown W, M, C
<i>Mavabzi ya timbilu</i> <i>or tesawu</i> (Heart and blood problems)	Heart failure and 'pain'; body pain, heating on the feet; dizziness.	<ul style="list-style-type: none"> Lack of emotional or social stability: financial difficulties, lack of job, marital problems; anti-social children, and the like. 	Neutral W, M, (very rare in Children)
<i>Ndapsa</i>	Frequent swelling on the feet. Lack of will; depression, stress traumatic.	<ul style="list-style-type: none"> Lack of emotional or social stability: financial difficulties, lack of job, marital problems; anti-social children, and the like. Possessing spirits 	Neutral W, M
<i>Xithetho</i>	White or cream-coloured, smelling and dense mucosa in the genitals; may lead to incapacity to reproduce.	<ul style="list-style-type: none"> Bodily type of <i>ngati</i> that creates a nucleus in the reproductive organs; dysfunction of the female reproductive system Or 	Neutral W

¹⁴² During the research I understood that the *tinyanga* who are familiar with AIDS are those who underwent biomedical training on HIV & AIDS programs.

¹⁴³ This is an innovation by the *tinyanga* from Manhiça (Calanga – Nsihanine) encountered in the participatory mapping of local types of illness. They say that from the way they encounter the illness, in the community and from different seminars, they understood that it develops and is a 'chameleon blood' because does not have a clear shape and type.

Sickness	Representation	Aetiology	Gender
	The uterus hardly holds the sperm.	<ul style="list-style-type: none"> • Possessing spiritual agents Or • Other spirits (spiritual involvement) 	
<i>Xilume</i>	<p>Temporary (until treated) or definitive infertility. In the long term it reduces the chances of getting pregnant.</p> <p>Constant miscarriages when the illness is female; or post partum child death when it is male¹⁴⁴.</p> <p>Characterised by nausea and severe headache and pain during or prior to the menstrual period.</p>	<ul style="list-style-type: none"> • Physical disorder Or • Spirits (spiritual involvement) Or • Possessing spirits • Congenital 	<p>Xilume xa mpsele (female)</p> <p>Xiluma xa duna (male)</p> <p>W</p>

The table show that indigenous medical classification of illness shares some sicknesses with biomedicine such as malaria, gonorrhoea, and anaemia but the representation of these ailments in indigenous healing is shaped by the way the human body is represented. For instance *ngati ya xikandzamethil* the 'agent' that provokes gonorrhoea is known to create a nucleus (*rhanga*) in the blood. Due to this, people would always take traditional medicines along with pharmaceuticals prescribed by hospitals. It is conceived that only traditional medicines (*xilovekelo*) have the capacity to eliminate the *rhanga*. The pharmaceuticals just clean the bad blood without eliminating this *rhanga* that destroys the blood and weaken the person gradually.

From the perspective of the patients there is an array of illnesses within the landscape. They know how to assign every sickness to each medical tradition and service. In this processes some diseases are represented exclusively with the knowledge of indigenous medicine or biomedicine. Others are represented with the epistemology of both medical traditions.

I argue that this typology of illness of indigenous medicine also brings evidence to support a 'medical universal' which is that all medical practices have their own sort of sickness and the

¹⁴⁴ The gender of an illness has nothing to do with sex but with intrinsic characteristics such as its severity and impact. (see below)

capacity to incorporate new illnesses in their typologies, amid innovations and processes of social (ex)change. Despite the sicknesses intrinsic to indigenous types, the classification also shows those that are known worldwide, that in the past were pandemic, and that were reduced by planned interventions undertaken in biomedicine. *Xitshinana* (measles) is one example of these sorts of illnesses.

Sicknesses are divided into different groups associated with generations and sexes. There are sickness associated to children and others for women and men. The classification is also associated to parts of the body¹⁴⁵ and gender where they can be male, female or gender neutral. The gender of an illness has nothing to do with sex but with intrinsic characteristics such as its severity and impact.

These sicknesses are not static types and propositions. Both the *tinyanga* and lay people conceptualise them and manipulate their social meanings in the practices and therapeutic processes in which they are diagnosed and healed. For example, within this process sickness may be gendered or given other aetiologies. *Xithetho* does not necessarily imply infertility but since the society is patriarchal and the relations of power are dominated by this, the women's infertility is quite often associated to this sickness, sometimes precluding the man's incapacity to reproduce.

5.2.2. Diagnosis

The *tinyanga* diagnose illnesses using different forms of techniques. The most common are observation and elicitation of narratives and illness history, and *kuhlahluva*. Only a *nyamusoro* or a *nyamusoro* (*nyanga*) can perform the *kuhlahluva*. The other forms of diagnosis are used by all types of *tinyanga*. In *kuhlahluva* they use diagnostic instruments/tools (*tinhlolo*) or spiritual agents

¹⁴⁵ Not demonstrated in the table

(*kuhlaluluva hi svikwembu*).¹⁴⁶ In observation they examine the body-spirit of the patient, and in the elicitation process there is a conversation between the *nyanga* and the patient in which the patient responds to the therapist's questions related to different aspects of the sickness (history, severity, previous solution measures, etc).

5.2.2.1. *Kuhlaluluva tinhlolo*

Local anthropological literature classes *kuhlaluluva* as “divination” (See Earthy 1933; Granjo 2005; 2006; Honwana 2002). I do not find *divination* a useful concept because the *tinyanga* themselves do not consider it as such and does not capture the practice of *kuhlaluluva* and the way it is represented by the *tinyanga*. People in the south of Mozambique, in particular the *tinyanga*, do not identify themselves with this concept. They claim that ‘divination’ means *kuvumbata* which means to *predict* or *guess* something. In *kuhlaluluva* the *nyanga* may predict or guess in some of the diagnostic sequence but this is not the essence and main objective of the *kuhlaluluva* process. This practice uses five main sources to deliver the consultation: (1) the reading of the mathematical and mechanic disposition of the *tinhlolo* when they are ‘thrown down’ (*kudiba tinhlolo*)¹⁴⁷; (2) the utilisation of discursive devices to discern and elicit life histories and memories of the patient(s); (3) the observation of the psychological and physical profiling of the patient(s) to reach a consensus and conclusions about the appropriate action to heal or prevent an illness or misfortune; (4) the questioning of the patient(s) to clarify and negotiate the diagnosis, and (5) an attentive “auscultation” of the patient(s) explanation and positioning with the *nyanga* observations and findings. Taken this, the concept of “divination” reduces the phenomenon and reflects the ideologies and epistemologies of its proponents about this type of diagnosis.

The main *kuhlaluluva* instruments, *tinhlolo*, are a set of diagnostic tools. They are typically constituted by three main groups: one larger group of small objects just called *tinhlolo*, and two

¹⁴⁶ see explanation of *tinhlolo* and *kuhlaluluva hi svikwembu* below

¹⁴⁷ see below

small groups' one called *tihakata* and the other called *tingwenya* or *svingwenyana*. All *tinyanga* that perform the *kuhlahluva* use the first group of *tinhlolo*, which are associated with *Nguni* spiritual agents. Local histories say that the *Nguni* introduced the *tinhlolo* during the Gaza Empire. The use of *tingwenya* and *tihakata* depends on the spirits that 'work', i.e. that use the *nyanga*, to perform the diagnosis. The *tingwenya* are used by the *vahlonga* (descent spirits) and the *tihakata* are associated to the *Ndau* spirits. The three groups were divided this way in the past. Some of the *tinyanga* that I studied use both the *tihakata* and the *tingwenya* but others just use one or the other, along with the larger group of *tinhlolo*.

Photo 7. *Tinhlolo* (Big group)



Photo 8. *Tinhlolo* (*Tihakata*)



Photo 9. *Tinhlolo* (Tingwenya)



The big group of *tinhlolo* is made up of small, specific and selected objects from bones of animals, plants, cockles, coins, stones, etc and represents the society, family and the body-spirit. These objects are symbolic devices used in diagnosis to represent the body – spirit, family and society, and to give a meaning in which the symbolism makes and is given sense and actualised in the diagnostic performance involving the *nyanga*, the patient and the spirits. The bones of animals, pieces of plants and sea-shells represent the male and female genders and are typically extracted from male and female animals and trees¹⁴⁸. The coins are both local and foreign. The stones are generally precious stones. The bones are selected from various animals including lions, gazelles, wild pigs, ship, goats, turtle, pangolins and hyenas. The pieces of plants are selected from the marula tree. The sea-shells include bubble shells, ceriths, rock snails, etc.

The *tinhlolo* represent people and social reality and the way they are selected and used is subject to the same rules of social change. Other *tinhlolo* have been added in the last decades and each *nyanga* tends to have some particular objects that represent what is more important in

¹⁴⁸ Plants are classified by gender as well.

contemporary health seeking behaviour. For example, some have introduced objects to represent cars, aeroplanes and guns.

The *tinhlolo* are a complex apparatus of symbolism, mechanics and mathematics. The *tinyanga* usually spend more than twelve months learning how to use them. Hence I cannot elaborate fully here the knowledge surrounding their classification, symbolism and (mainly) utilisation. However it is possible to continue with the description presenting a summarised way in which they represent the body – spirit, family and society.

The *tinhlolo*, when thrown, represent the household, lineage and/or community. The way they fall has to show a division between the mother's descent (*kaya*) and the father's descent (*kavalokwana*) and tells the history and social situation of the patient(s). The coins represent finances of the patient(s), the red stones symbolise the *tingati* (different types of blood), and the black stones *ntima*, *xisila*, *munyama*, death, etc. The smaller sea-shells connote different descent ancestors. The big one (like the button shell) represents the *khosazana*; the present and previous (deceased) Chief's elder sisters. The gazelle's *tinhlolo* (bone) are called *mhunti matlhari* and can represent among other things a warrior or a spirit of a warrior and those who died without wives (*tingwhendza*); wild pig's *tinhlolo* are called *tinguluve* and represent the *vahlonga* spirits (from the lineage also called *tinguluve*); the ship is called *hamba kufuma*, the name of the *tinhlolo* for the chief, high level leader, *tinyanga*, etc. The goat's *tinhlolo* are divided in sizes to represent different stages of life: children and adolescents (*malumbe*, the male and *nhombela*, the female); married men and women until their 40s are *nsati wa tinhenga* (female) and *nuna wa tinhenga* (the male); old women (*nsati wa nhlanguwana*) and old men (*ndota*). The goat *tinhlolo* also represent the widower (*nuna wa tinoni*) and widow (*nsati wa tinoni*).

The other groups of *tinholo*, the *tingwenya* and the *tihakata*, used by the *vahlonga* (descent spirits) and the *Ndau* spirits respectively, are divided into subgroups of six instruments each.

The former are parts of a crocodile (*ngwenya* = singular) and the later, objects from a tree called *xitsalala*. Both the *tingwenya* and the *tihakata* are subdivided in sets of three objects representing the female gender and the other three symbolising the male gender (of human beings or animals).

The practice of *kuhlahluva* in the actual *nyanga* – patient(s) encounter is sequenced. I will give some summarised examples of *kuhlahluva* below.

Photo 10. Typical session of *kuhlahluva* (the *nyanga* in red, me observing in the right, and the patient in black)



5.2.2.1.1. João's Case of *Kuhlaluluva*

This case documents a diagnosis between João, his mother and Adelia, the *nyamusoro*, in Maputo.

João went along with his mother and brother to the consultation. Before starting, when the patients were around twenty metres from the *Ndhombha*¹⁴⁹, the *nyamusoro* Adelia, looked

¹⁴⁹ The *ndhomba* is the name of the place set aside for the *tinyanga* treatments and where their spirits stay.

cautiously at the patients and said to me: *atinhlolo ita jaha le rakuzemuka!* the young tall boy is the centre of the consultation. She then said she knew because “she could see” (*nhosvivona*), she was told by the ancestors) but, she continued, it was also obvious in the mood and motions of the young boy. His mother was more relaxed and had been more communicative when waiting than this young boy... “This is a family issue but he is the one who is more frustrated and demanding a solution (...)”. I asked how she knew that they were family she cited *nhosvivona* again. The family came in, she greeted them and they stated that they had come for a consultation. She then threw the *tinhlolo* and the diagnosis begins:

Nyanga: *I have to throw them again. What is your (family) name and the name of your mother (vakokwana)?.*

João's brothers: *We are Macandzas and my mother is Chilaule.*

Nyanga: (shaking the *tinhlolo*) *we want to know about the Macandza's health (...) will the spirits get together with the Chilaule ancestors and tell us what is happening? (She throws the tinhlolo).*

She analyses the *tinhlolo* and (speaking to them) says that João's *mabizweni*, the spirit who he was named after (called Samusone), was saying that he does not come from his father's lineage (*kaya*), that he is not Macandza but Chilaule. She takes the *tihakata* and the *tingwenya* (the two pairs of six each) to ask specific questions to confirm what had been said. She continues to say what she sees and hears and the family respond *siyavuma!* (a sort of refrain meaning we are following you). This refrain also gives rhythm and flow to the ‘turn-taking’ (*kuvumisa*). After tracing the history of both the Macandza and the Chilaule, Adelia (the *nyanga*) stops the rhythmic ‘turn taking’ and asks the patients to confirm what she has said, but before she does so, she repeats:

Nyanga: *The tinhlolo are saying that you came here because Samsone is not doing well, his life is not going well (...) he gets a job and is fired although he is competent (...) he does not sleep (...) he is depressed, he has a constant headache, body pain and vertigo (..) We could treat him but*

things will not improve since the Chilaule's ancestors are unhappy with the all family because their paraphernalia no longer exists (...) you just take care of the Macandzas (...). You mabizweni (Samsone) is also complaining that since you have grown up you are not taking care of him (...).

She asks Jão if he had the Samsone's (his *mab'izweni*) *capulana* and he responded no. She continues, explaining that when João got his first job, he did not present the first earning to his *mab'izweni*...

Nyanga: *When he (João) gets a job he has to solve this problem (...)*

João's mothers: *But he has to get the job first (...)*

After an hour consultation and dialogue they decide to move on to the solution.

Nyanga: *Let's move on to the solution (...).The first step is for mother to communicate with the ancestors (aphahla). Start with the Macandzas and then speak to the Chilaules. Use still water, it is the phika, meaning you are doing the kuphahla liberating them from their anger and acknowledging your mistakes(...) that is what the phika means (...).Just inform to the Macandzas that you are going to perform that ceremony (mhamba) to the Chilaules. Then to the Chilaules ask for apologies, promise that once the boy gets money he will buy their paraphernalia (...).*

Adelia continues the consultation saying that Samsone was a Ndau spirit who in the past was the spirit who worked with João's grandmother (his mother's mother).

João's mother: *Yes my mother was nyamusoro (...) She had Ndau, Nguni and vabaniyana spirits. She died 20 years ago, very old, and did (indigenous) medicine (atirhe wunyanga) for more than 60 years (...)*

Nyanga: *(...) Samsone is not even from the Chilaules. Chilaules is where you mother come from but this wunyanga that Samsone comes with belongs to your grandmother's side (...).*

João's mother: *Yes they are from Machava family (...) at that time the nyanga was Kokwana Yandheya (...).*

The *nyamusoro* consults the *tihakata* and the *tingwenya* again and she proceeded with the conversation.

Nyanga: *Your social stability and good luck (njombo) comes from these Machava ancestors indeed; so now, with this Samsone (...) when you communicate with them (the ancestors) pass the Chilaula, as you would have done with the Macandzas, and give all the credits to the Machava (...) do not forget to direct everything to Yandheya because she is ultimately the head among them (...). When all this is finished you can be treated (your xiviri) because the ancestors provoked xisila (...)*

In this *kuhlahluva* process, the *nyamusoro* started with profiling the family in terms of kinship relations and emotional status. She set the scene by asking about the interests of the patients, their relationship, and the degree in which they are involved with the problem that brought them to the consultation. Here the *nyanga* used the diagnostic apparatus drawing on her abilities, the *tinhlolo* and the spiritual agents who partially¹⁵⁰ possess her and transmit their knowledge and diagnosis.

The consultation process generally involves the utilisation of linguistic devices of; *inter alia*, a rhythmical communication process (turn-taking), elicitation of life histories, and the recalling of memories. The life history of each patient that the *nyamusoro* reads in the *tinhlolo* differs from family to family. During my field work I did not see what Granjo (2005) calls "(...) the *tinholo* (hand tools - *sic*) song, a learned vague story about client's family and past that more or less fits most of

¹⁵⁰ In *kuhlahluva* the *nyanga* does not come into trance but partial possession whilst in full trance-possession the spirits (host) take control of the *nyamusoro*'s body (quest).

the population”¹⁵¹ (p13) but instead the *nyamusoro* described different life histories, which, with an ethnographically and linguistically sensitive approach can be seen as such. The family negotiates the life histories with the *nyanga* recalling the social history of the lineages. This negotiation aids the participants in reaching a consensus and allows the *nyanga* to clarify the diagnosis and continue on the right path. In this social history and kinship structure of the patients, the *nyanga* diagnoses the nature of the problem, which in João’s case was misfortune and social distress that resulted in physical impairment. The sources (*xivangelo*) of the problem were identified as a disjunction between the ancestral ancestors and the family and the *xisila* that came about. The solution (*nhlulelo*) was the performance of *mhamba* involving a certain form of communication with the ancestors, including an apology, symbolism, the paraphernalia, and medical performance. This is a one way process in which it is assumed that the ancestors will forgive the family and reshape João’s *xithuzi*, networks and restore his social will.

5.2.2.1.2. The Maluana’s *kuhlahluva* case

This case documents a diagnosis of the Maluana community problem.

Maluana region in Manhiça has a very special historical significance since it is apparently where the first gunshot of Maputo province was fired during the civil war in Mozambique. The community states that as a result of the bloodshed, Maluana was ‘polluted’ with *ntima* and became infertile, people’s productivity dropped and the will to work declined. Errant spiritual agents of those killed during the war were moving around provoking accidents and disintegrating local households, mainly those of the local leading lineage of the *Régulo*. The bloodshed left *ntima* behind for the Maluana families and provoked stigma/bad projection (*munyama*).

¹⁵¹ “(...) many of them (the *tinyanga*) even «sing the tinhlolo (sic) song», a learned vague story about client’s family and past that more or less fits most of the population.”

The local population, guided by the local traditional authority (the late *Regulo* Xirindza, brother of the current Queen), decided to solve this social affliction and went to consult a local *nyanga* (Monica Massingue) and ask about the actions to be taken in order to solve the problem. The *Régulo*, his aunt, two local *masungukati* (counselors/alderwomen), and three *Chefes de terra* of the *Regulado* (Chieftdom) were involved in the consultation. They called the *nyamusoro* to the *Regulo*'s house, where the royal seat is based.

Monica's *tinhlolo* were similar to those of Adelia (from João's case) except she did not use the *tihakata* on that day. The *kuhlahluva* (diagnosis) aimed to identify the causes of suffering of the Maluana community. Using a slightly different style but with the same basics nuances, Monica's consultation took three hours and showed that the suffering was not provoked by witchcraft, but rather by errant spirits, the ruling lineages ancestors, and the *ntima* surrounding Maluana. It was discovered that the problems started before the civil war when *Regulo Xirindza*'s father passed away in the 1980s. He was not reintegrated and the 'royal' family did not take the necessary actions to mitigate the problem because the family had disintegrated¹⁵². When Xirindza (Senior) passed away his *ntima* affected the living and the dead. The elimination of the *Regulado* (chieftdom) by the state destroyed the *tindhombha* (plural of *dhombha*, the 'house', cloth and tools of the spirits), and with it, all the social ties and spiritual support for the community. The spirits from the *Xirindza* (father's lineage), Massango (mother's lineage) and the *vakon'wana*, were displaced from their home and became errant along with the foreigner spirits of those killed in the war (*svikwembu sva matlharhi*). There was a family that migrated to Maluana headed by a man called *Mabihi*. The whole family was burned to death by RENAMO just after the starting of the Civil war. *Mabihi* was the bravest among all the foreigner spirits and became an avenging spirit demanding to be hosted in the *Xirindza Chieftdom* (*regulado*). He and many others who died there during the civil war were moving around creating misfortune since they needed to be cleansed

¹⁵² Recall that at this time traditional authorities were replaced by the socialist government structures

and reintegrated into the community. The political phenomenon of the displacement of traditional authority and civil war therefore sparked the emergence of new avenging spirits in the local landscape.

The diagnosis outlined above focused on the agency of the ancestors and social 'impurity' as the main problems to be targeted by the healing process. The solution was that a ceremony (*mhamba*) should be organised for the social reintegration of the 'Royal' lineages and foreigner spirits, and the healing and cleansing of the community, and to present the ancestors with their new paraphernalia. The foreigner spirits should be given a house close to the National Highway 1 and called to rest there. Those Mozambican families who lost their loved ones during the civil war or in accidents in Maluana could come to that *thepela* (shrine, house of the spirits) in the future to take the ancestors home for their ceremonies of social reintegration (*timhamba*).

The *kuhlahluva* (diagnosis) in this case in Maluana involved a number of community figureheads and the *tinyanga*. The Xirindza lineage of the *Régulo* represented the link with and the memory of the community. The affliction provoked by the political displacement of traditional authority was also represented in this lineage. The civil war became part of the problem of local suffering and *munyama*. The *timhamba* (social reintegration ceremonies) were ways of reconstructing and rebuilding social networks, cleansing social impurity, healing historical memories and the trauma of violence, reintegrating the deceased agents, ending the mourning, and mobilising the community back to production.

5.2.2.2. *Kuhlahluva hi svikwembu* (Diagnosis with spirits)

This case documents a diagnosis with spirits (*kuhlahluva hi svikwembu*) from Maputo.

It was the fourth time that Jaime was attending a consultation. He has been taking medicines from *nyamusoro* Chilaule for his problem of bad smell but he was not improving. Prior to indigenous medicine he attended different hospitals and took pharmaceuticals as well. *Nyanga*

Chilaule suggested: “*We should consult Dumezulu to see if he could give us a better solution for your problem (...)*”. Dumezulu is his Nguni spirit which performs the *kuhlahluva* through trance-possession and aids him in the diagnosis with the *tinhlolo*. Jaime, Chilaule and his wife went to the *ndhombha* to commence the diagnosis. The *kuhlahluva hi svikwembu* involves an assistant (*nyawuthi*) to help the *nyamusoro* with the all process including the translation from Nguni to Changana. In this diagnosis the *nyanga*’s wife was the assistant. Jaime paid the six hundreds meticaïs (13 pounds) which was the cost of this sort of *kuhlahluva*¹⁵³. Chilaule presented the money to the ancestors: “To you vovo *N’wantonga* (Chilaule’s grand grandmother from mother’s lineage, *vakokwana*, from who he inherited the *nyamusoro-hood*), tell the *vandau* and Dumezulu with his *vanguni* (...) he must come (through trance-possession) to see the problems of this young man (*avona timhaka ta jaha lerī*) (...)”. Then he sits facing the *mutundu* (paraphernalia and tolls of reintegrated spirits) and starts wearing Dumezulu’s paraphernalia which encompasses two different types of spears, a white and red t-shirt, a black capulana, three types of collars (*mupakatu*), and a Nguni *chovo*. The trance-possession commenced: sequential yawns, changes in the tone of the voice, his body starts to shake, intermittent but controlled ... Then Dumezulu took control of Chilaule’s body and said “*yo bese kunjalu*” which is the typical rhetoric of the Nguni spirits in trance possession. Chilaule’s wife gave him his little chair, he took a seat and they undertook a three minute greeting (*kudrungulisa ndzava*¹⁵⁴).

The conversation between the *nyanga*-spirit and Jaime was translated by Chilaule’s wife and started with Dumezulu making fun of the fact that his *ligodo* (Chilaule)¹⁵⁵ had failed to solve Jaime’s problem. Dumezulu proceeded, narrating all the history of the illness and Jaime’s

¹⁵³ By the time I finished my fieldwork the cost of *kuhlahluva* with the *tinhlolo* was 200 meticaïs (approximately five pounds).

¹⁵⁴ The *kudrungulisa ndzava* is a greeting event typical in *bantu* communicative practices.

¹⁵⁵ *Ligodo* is what the Host is called in relation to the guest. For example, Chilaule is Dumezulu’s *ligodo*.

experience with the stigma associated with the bad smell. Jaime participated in the interaction and, among other things he emphasised that he has lost his young wife for another man and that when teaching at the school where he works, he could see the student's annoyance with the stench. Dumezulu said that the problem was being caused by a very rare blood that is generated from his stomach and intestines (*ndzeni...ka xijelu ni marhumbu*) and spreading thorough his body to the skin and mouth.

He said that all the therapeutic procedures were being well performed by both the *ligodo* and Jaime. However, his *ligodo* was failing in the preparation of the medicine¹⁵⁶ that they were using. Chilaule had prescribed the boiling of that medicine. Dumezulu changed the prescription and recommended that they should first burn the roots and the stem of the medicine and use the powder from the charcoal to treat Jaime's sickness...

The *kuhlahluva hi svikwembu* from Jaime's case involved the *nyanga-spirit*, the assistant and the patient¹⁵⁷. The apparatus of the diagnosis also included the involvement of other spirits who are participating in the communication with Chilaule and communicating among themselves upon the *nyamusoro's* request. The spirit reshapes the identity of the *nyamusoro*, takes control of the therapeutic encounter and becomes the therapist himself. He assumes a more powerful position than his *ligodo* in the turn-taking process, mainly in terms of confidence and exposition of the therapeutic knowledge.

The Dumezulu *kuhlahluva* took around an hour and half. Others I observed that were directed by him, especially with families and in households, lasted more than two hours. In João's consultation, and in others I participated in, Dumezulu prides himself in being a good and tireless speaker. I also noted a similar behaviour in other Nguni spirits in *kuhlahluva* and during the

¹⁵⁶ I have agreed not to disclose the names of the medicine used in indigenous medicine.

¹⁵⁷ I am not including my own presence in the scene!

apprenticeship. This contradicts Granjo (2005) and his supposition that “(...) it is believed that the spirits (especially if they are Nguni) don’t work for very long (...)”¹⁵⁸ (p15).”

5.2.2.3. The examination of patients (Observation)

This case documents a diagnosis made through a physical examination (observation) in Manhiça.

In the description of the case above I do not refer to my own presence in the therapeutic events. The participant observation depicted is not as disengaged as it may seem to be. In several events during the fieldwork I (and those who joined me) sometimes turned into research subject, as in the case I describe next.

A friend of mine who intends to do her future fieldwork in Manhiça joined my research there several times in order to get familiar with the context. When we were doing a participatory mapping of types of indigenous medical illness the *tinyanga* said that the sickness *kutshamiwa* was what my colleague apparently had. They asserted that they have been watching her but could not help because it was out of context and purpose. Doing the mapping was the right opportunity to try to confirm the diagnosis and give her some advices. If it was *kutshamiwa*, they told her, she would be experiencing misfortune and problems with reproduction. I was perplexed because she had turned into my research subject and the *tinyanga* was asking her to become a patient. I was in an ethical dilemma, and had to ask her if she was willing to follow the line of that conversation and she said ‘yes’ because she knew that one day we would have to bring the participation process into our lives. She also said that she had a lot of questions about her family life that had never been addressed with the *wunyanga* because her kin are from the hard line of the Marxist system. She explained she had always been confused about the misfortune in her life but could not do anything because her parents taught her not to “believe” in indigenous

¹⁵⁸ The quotation includes the words in brackets.

medicine¹⁵⁹. But she wanted to proceed because maybe that would explain the reason why her first born son is 18 years old and her next born is only four years old. She struggled to conceive again for fourteen years. I said to the *tinyanga*: “you do not seem to be sure if she really has the *kutshamiwa*.” Three of the *tinyanga* present said that they should examine, or ‘observe’ my colleague, but they would have to do this inside the house as they would need to see the genitals¹⁶⁰. They went in and came out after a twenty minute observation. They confirmed the preliminary diagnosis of *kutshamiwa*. “The signs of *xisila* and *munyama* are not hidden; especially in the vagina (...) between the buttocks they can mislead but are evident again in the anus (...) – *nyamusoro* Maria.

In this observation the *tinyanga* did not need my colleague’s narratives and illness history to confirm the diagnoses, although she did describe some social constraints associated to her reproduction history, they just required an examination of specific signs in her body that represented the sickness. The use of observation of the body in the diagnosis of *kutshamiwa* signifies (as shown in figure 3) that there was an association between my colleague’s reproductive problems, and misfortune with the *xisila* in her body-spirit and the signs in her body. The *tinyanga* said that that *xisila* was simultaneously traumatising her *xithuzi* (social projection, identity, self) and denying the body from getting pregnant as well. Hence *kutshamiwa* is in the social realm (*kunyama*), body-spirit (*xisila*) and physical body (*infertility*). It is reflected in all these realms, and not separately in just one of them.

The four cases presented above have shown that consultation may involve different sorts of social agencies and spiritual agents, and different techniques of inquiring into illness. The health problems lie in the family, lineage, individuals and community. The causes of the problems

¹⁵⁹ Her father was assimilated during colonial time and her mother a well positioned FRELIMO figure.

¹⁶⁰ This participation was conducted at the house of one of the *tinyanga* where I was hosted in Manhiça - Maluana.

involve 'bodily' processes, spiritual agents, social, political and historical events such as war and different forms of government. The recommended solutions encompass different strategies using pharmacopeia and rituals as described above, and symbolic - performative strategies which are discussed in the next paragraphs.

5.2.3. Therapy

The therapy of indigenous medicine uses, but is not limited to, the pharmacopeia, and symbolic – performative therapeutic strategies¹⁶¹ to engender transformation from illness to health.

5.2.3.1. Pharmacopeia

I use the term 'pharmacopeia' when referring to all local models of identification, preparation and use of medicinal resources of indigenous medicine to restore health. It encompasses elements from the animal world, minerals, elements from plants and hydro-products¹⁶². These components are harvested in several locations. The collection of some of these indigenous medicines require different sorts of rituals, in well prescribed times and spaces. The medicines are used either dry and/or fresh. In plants the pharmacopeia is divided into leaves (*matluka*), roots (*timpande*), fruits (*vana/ timbewu*), stems (*makopa*), juices of their liquids (*mafi*) and flowers (*sviluva*), in their natural form or powdered. The elements from the animal world are classified in their natural form, skins (*svikhumba*), teeth (*matinyu*), bones (*marhambu*), nails (*minwala*) and blood (*ngati*). The hydro-products include water shells, fungus and plants from the lakes, sea, rivers and marshes (*svibowa*). These medicinal resources are categorised in their natural form or in powdered form as *tinhunguvana*. *Nhunguvana* (single of *tinhunguvana*) is the common category for all medicinal resources.

¹⁶¹ By symbolic-performative therapeutic strategies I mean the indigenous medical practices *by* and *through* which health, therapy, efficacy and identities are produced, constructed and represented using a concatenation of symbols, language, medicines and individual or collective performance.

¹⁶² From the lakes, sea, rivers, marsh and so forth

Table 6. Classification of indigenous medicines

	Flora	Fauna	Hydro-products	Minerals
Category of medicine				
<u>'Natural' form</u>	<i>Matluka</i> (leafs)	Svikhumba (skins)	<i>Svibowa</i> (sp. aquatic plants)	Example, Salt and Sulphur
	<i>Timpande</i> (roots)	<i>Matinyu</i> (fangs)	Shells	
	<i>Vana/timbewu</i> (fruits)	<i>Marhambu</i> (bones)	Aquatic animals	
	<i>Makopa</i> (stems)	<i>Minwala</i> (nails)	Fungus	
	<i>Mafi</i> (juices of their liquids)	<i>Ngati</i> (blood)		
	<i>Sviluva</i> (flowers)	Other parts (organs, excrements, etc)		
	Seeds (<i>timbewu</i>)			
<u>Powdered</u>	<i>Tinhunguvana</i> (powder)	<i>Tinhunguvana</i> (powder)	<i>Tinhunguvana</i> (powder)	<i>Tinhunguvana</i> (powder)

The pharmacopeia of indigenous medicine also categorises the medicines in terms of their gender – male, female and gender neutral. The gender of the medicines derived from animals is associated with their sex, and likewise of the hydro-products. The minerals are gender neutral. In plants there is not always a necessary relation between the gender of the medicinal plants and their capacity to reproduce. The gender of some plants, however, is related to their intrinsic ability to ‘reproduce’ the species. Plants that can replicate their species are typically females while those which cannot are males. In other cases their gender is defined according to their functions and characteristics. For example, the plants *himbi* and *nkanyi*, (*Gracina livingstone* and *Sclerocarya birrea* in biological ethnobotany)¹⁶³, are gendered in terms of male and female. The female are those that can give fruits (*mahimbis* and *makanyi*) while the male are those that cannot. However, any plant that heals female sicknesses may in some cases be called female regardless if it can reproduce the species or not. And vice-versa with those plants that restore health in people with male illnesses. The plant aloe (*mangana*), for instance, can be male and into this group fits for example what in biological taxonomy are considered to be species *aloe Marlothii* and *aloe Arborescens*. Their male gender is defined according to their aggressiveness, toxicity and the type of diseases they heal. The *mangana* can also be female and into this category fits for example what is known in biology as *Aloe Vera*. They are known as female *timanghana* (plural) because they treat female sicknesses and are considered to be more “delicate”, with less “toxic” agents which are thus used to treat (for example) eyes and babies. This classification partly reflects local representations of masculinity and femininity available in the local socio-cultural environment.

In treatment, when the male and female medicines are used, a number of things are taken into consideration, including other medicinal resources, timing of treatment, and size of the patient. The

¹⁶³ *Mimbhimbi* and *minkanyi* (plural forms)

medicines can treat illnesses both from within their gender and from opposite gender classes. For example, an effective therapy for male infant diarrhoea is using the female *mhangana* and *Himbi* medicines, demonstrating efficacy being influenced by the use of a plant of opposite sex from that of the patient. There are also illnesses that, despite their gender, require the male and female medicinal resources to be combined. A female *nkanyi* may be appropriate to treat a sickness of the same gender class or can be combined with a plant of opposite gender to treat another specific illness. So, there is a complex network of meanings behind the relationship between the gender of medicinal resources and sickness.

5.2.3.1.1. Treating Jaime's problem

Jaime, who went to the consultation with *the mungoma* Nguni spirit (*kuhlahluva hi svikwembu*) with the ongoing problem of excreting strong odours, returned to the *nyamusoro* Chilaule for treatment the following day. The *ligodo* (host) Chilaule and Jaime agreed to do the treatment around 11:00am as Chilaule would need to prepare the medicine in the morning. He did not have the plant in stock and did not want the patient to see the preparation. After the patient (Jaime) had left I asked Chilaule where he was going to collect the plants to prepare the medicine.¹⁶⁴ He told me that it was in a forest close to an old farm 21 Km (13 miles) from his *b'andla*, north of the City of Maputo. We agreed to go early in the morning before the sun rose. The next morning we went to harvest the leaves and stems of the plants.

We came back with the stems and leaves, and started the preparation of the medicine together with his son. I had to help in this process because of the norms of interaction established by our

¹⁶⁴ I knew the plant that he was using. He agreed to share knowledge openly with me because I am *nyamusoro* too and we would work together for more than six months. He treated me as *ntukulu* (grandson) because he is an elder *nyamusoro* who graduated *tinyanga* of the generation of my *b'ava* (master). In order to protect his right to that knowledge, I will not divulge the names in this thesis.

relationship and several other tacit norms of sociality. We prepared a big fire and used enormous sheet metal to burn the plant, mainly the leaves and the small stems. The bigger stems were put directly into the fire and controlled so they could not mix up with the wood. Both the stems (*makopa*) and leafs (*matluka*) became charcoal after approximately one hour of burning. Then they were left to cool and taken to a big pestle and mortar (*churi*) and pounded. Chilaule stored the *nhunguvana* in five glass flasks of the size of big mayonnaise jars. Then he said: "This medicine will last for a very long time and I will use it in many more patients" "(...) thanks to Dumezulu, Jaime's sickness (blood) was confusing me / *ngati leyi yivabzaka Jaime ayiniphamba* (...). Do you want some to use with your patients?". I said no I would prepare it myself because it was easier for me to harvest and get assistance in the preparation than it was for him.

We stayed in the *dhombha* (the 'clinic') waiting for Jaime and chatting about my thesis. This time Chilaule was very interested in knowing if my teachers (*vathica*¹⁶⁵) would understand indigenous medicine. This was not his first time asking. I explained to him (again) that I think they would understand because they taught me how to explain things in writing using their models of thinking.

Jaime arrived thirty minutes early that morning. He paid two thousand metical (forty pounds) for the treatment. As before, Chilaule did not present the money or medicine orally to the ancestors. He just put the money in their *phandze*¹⁶⁶. This is a practise I had previously observed in other *mab'andla*. My understanding is that it is tacitly agreed that both the spirits of the patient and of the *tinyanga* are

¹⁶⁵ *Vathica* is used in Ronga and Changana and derives from the English word teacher. They also use word *prisori* derived from the Portuguese word for teacher, 'professor'. The singular form for *vathica* is *thica*. My *vathica* in the case of my thesis are my supervisors and examiners.

¹⁶⁶ The *phandze*, has the main source of power and capabilities of the *wunyanga* to heal and recruit patients and students (see previous footnote above).

there to use their power to produce efficacy. Jaime was then given the medicine and the prescription....

Some weeks later, Chilaule told me that Jaime's health had improved dramatically and he no longer suffered from the problems of strong odour on his breath and in his sweat. He also said that, having heard of Chilaule's problems watching TV programs with adult content with the children, Jaime bought him a new television to use in his bedroom, as a sign of appreciation for the treatment. He also gave him some money for Dumezulu which he expects his wife to hand in when Dumezulu comes (*ahuma*) anytime soon.

All the therapeutic processes described involved the *nyamusoro*, his son and the spiritual agents.

5.2.3.2. The *Phungula*

Previous anthropological definitions of the *phungula* therapy have been attempted by anthropologists who work in Mozambique, but these definitions need revision. For example Granjo (2005; 2006) describes it as follows:

“This kind of sauna, the «*bath*» or «*breath*», is a very common treatment, where only the boiling ingredients change according to the desired effect. Besides the health purposes, it can be used for purification, protection or even as one of the exorcism techniques – the so-called «*plants kufemba*» (Granjo, 2006, p16)”¹⁶⁷.

Here the *phungula* is depicted as bath or inhalation and its ethnography described as a ‘very common treatment’. The perception is also that purifying and protecting the body-spirit (*miri-xiviri*) is not just for health proposes. This does not seem ethnographically sensitive because it negates the inter-connectedness of cleansing, purification and healing. The *tinyanga* use the

¹⁶⁷ Quotation from the original text in English

phungula as a tool through which therapies for cleansing, purification and healing (*Kuhlampsaxiviri*); recovering the parted *xiviri* and healing the body spirit (*kubuyisa xiviri*); the fortification of the *xiviri* (*kutiyisa xiviri*); upgrading of the *xiviri* (*kupfuxeta xiviri*), and for healing respiratory sickness are performed. These are the basic treatments, which may overlap, be interrelated or interdependent depending of the current state of the patient and the motivations behind the healing.

The techniques and sources of healing of *phungula* are complex. Part of the time taken in the *kuchayeliwa* (the training course of *wunyanga*) is devoted to the learning and apprenticeship and manipulation of this therapy. Providing too much detail about the treatments can also risk disclosing protected therapeutic knowledge. I will therefore restrict myself to describing the general aspects of how the therapy works.

The *phungula* is a therapy that requires a number of different ingredients including dry or fresh leaves (*matluka*) in their natural form together with the powdered form (*tinhunguvana*) of roots (*timpande*), fruits (*vana/ timbewu*), stems (*makopa*), flowers (*sviluva*) and minerals. Each *matluka* has its own therapeutic function and agency. The *tinhunguvana* can be either individual elements or a combination of elements. Each *nhunguvana*¹⁶⁸ is selected due to its functions and action. Some medicines have cleansing capacities. Others purify the body-spirit and there are also those which cleanse and purify the ancestors and are subdivided according to the category of spirits (origin/ethnicity and if they are *tinyanga* or not). Other medicines share the capacity to bring back the *xiviri*. The agency of each medicine however is combined with other therapeutic, performative strategies to bring about the change from illness to health. In some therapies that involve *phungula* the *tinyanga* also adds a small amount of blood from either a chicken, a special chicken with ruggles

¹⁶⁸ The singular form of *tinhunguvana*

red feathers (*xitlalu*) or a sheep. The variation between these animals depends on the social status of the patient. Sheep is used for people with the status of chief, (with *xiviri* and *xithuzi* of high social status). The *xitlalu chicken* is used for people with slightly lower status and normal chickens are used for ordinary people. The animal is typically the opposite sex of the patient.

The process starts with boiling water in a medium size or big pot. The boiling process is typically with charcoal or firewood. The *nyanga* mixes up the different medicines as appropriate to each therapeutic case. This always includes leaves, minerals and powder. For example, if the therapy is for recovering the parted *xiviri* and healing the body spirit (*kubuyisa xiviri*), the specific medicines for this will be mixed accordingly. The *nyanga* adds the medicines to the boiling water and leaves it for some time to mix together. This preparation is called *phungula*. The whole therapy is also called *phungula*. Meanwhile the *nyanga* or the *nyawuthi* (assistant – either kin or *thwasana/trainee*) prepare the place for the patient to carry out the *phungula* (*kuwora phungula*). The patients take off all clothes and put on a *capulana*, which they remove when covered. Sometimes they are left with shorts or underwear with or without *capulana* on depending of their gender and their therapeutic relationship with the person administrating the *phungula*. They can kneel¹⁶⁹ or may sit on a small stool, brick or a seat adapted from a trunk of tree. In this case, the patient sits in a bent position with opened legs to allow space for the hot pot. Then they are covered with a blanket. When the *phungula* is ready, it is placed under the blanket with the patient whose body-spirit is heated by the steam filled with the medicinal essences. The idea is to let the body-spirit absorb the selected medicines, or exude malicious elements into the steam, and to generally allow the medicines to perform their propose – which is to join the body and the *xiviri*, cleansing, purifying, or strengthening the body-spirit relationship

¹⁶⁹ The kneeling position is similar to the Japanese position 'seiza'; kneeling on one's own lower legs, with the feet under the buttocks, toes pointed backwards.

depending on the purpose. There is a *phungula* for flu where the patient inhales a vapour of eucalyptus but in the case of joining the body and the *xiviri* through *phungula*, there is no need to inhale. After some time, the patient is uncovered and the water in the *phungula* is separated from the remaining medicines and put in a basin for the patient to take a bath. This bath is just one part of the *phungula* and does not define the entire therapy. This part of the therapy in which the patient takes a bath is referred to by Portuguese speakers in Maputo as '*tomar banho*' (to take a bath). In Ronga and Changana it is called *kuhlampsa xiviri* (cleansing the body-spirit). Granjo's assertions (2006) quoted above are not linguistically and ethnographically sensitive since they seem to be using the Portuguese language to research indigenous medicine whilst this medicine uses the ideologies of Ronga/Changana cultural practises and have little ontological validity.

5.2.3.2.1. *Kuhlampsa xiviri* (purification, cleansing and healing)

5.2.3.2.1.1. Lora's¹⁷⁰ *Phungula*

Lora went to see the *nyamusoro* Joana¹⁷¹ on the day scheduled for my research discussion at her *b'andla*. My participation in their encounter was agreed by the parties¹⁷². Lora had been raped by a gang, somewhere in Maputo. She reported the case to the police and was referred to the hospital where she was seen by biomedical professionals who gave her psychological counselling and pharmaceuticals to prevent sexual transmitted infections including HIV & AIDS. She told Joana that although she spoke to the psychologist she still feels impure (*ninyamile*), absent, and out of sorts and

¹⁷⁰ Not her real name, which has been protected due to the sensitivity of the case.

¹⁷¹ This is not the real name of the *nyamusoro* which is also protected.

¹⁷² The *nyamusoro* she knew me from my talks on the national public television (TVM). She said that it was normal for a patient to be seen by the *nyanga* (*nyamousoro*) and her assistants, and that as an initiated *nyamusoro*, it was a pleasure to have me there... I agreed on an informed consent with her patient in order to use her history which is not detailed due to its sensitive nature.

unable to work and sleep. She said that she had told all these to the psychologist who prescribed some sessions to express her feelings and some pharmaceuticals to help her sleep. “I attended two sessions before coming here because they were free of charge and thought I would save some money (laughing). But I am still out of sorts and when my husband touches me my mind does not link with his contacts (...) I am not there (...) please help me *tia*¹⁷³ Joana”.

Joana said that it was normal to feel that way after that misfortune (*hlolwana*) and added that things should be diagnosed carefully to determine the causes (*axivangelo*). “(...) don’t worry my daughter, once we find out the causes of that *hlolwana* we will discover the right way of getting rid of that *xisila* that those vile attackers put on you.” Then she took the *tinhlolo* to start up the diagnosis, Lora paid two hundred *meticais* (five pounds) and they did the diagnosis. She said that what happened was misfortune (*hlolwana*), and thanks to the ancestors worse was avoided (*a vafi vebakanya mhangu*). There was nobody behind the problem¹⁷⁴ and the ancestors were all on good terms. She also said that the attackers had given Lora impurity in the body with their “illegitimate” and dirty blood (*vakunchimise hi tingati tavona*) and harmed her spirit and social projection (*vakuhise xiviri ni xithuzi*) by violating her female integrity and norms of sexual intercourse. The relationship between Lora’s *xiviri* and her body was unbalanced, traumatised and both were impure. This is the reason why Lora was feeling out of sorts, absent and her *xiviri* could not sense the touches in her body. She also said that Lora’s body had harmful blood from the violators, which is why the continuation of the intake of pharmaceuticals would be good. “(...) we do not have to change those pharmaceuticals (...) they will

¹⁷³ *Titia* means aunt. In local cultures people would typically call aunt to a women of their mothers generation. Similarly, *tio* (uncle) or *vovó/vovô* (grandpa/grandma) to people of the generations of their fathers or grandparents respectively.

¹⁷⁴ Meaning there was no spiritual cause of this misfortune.

clean up the bad blood from the attackers/ *hingatincinca makinina lawa matalimpa*¹⁷⁵ *ngati ya svigevengu.*”

Lora’s *xithuzi* should be restored, and her body-spirit cleansed, purified, and healed. In this process the relationship between the body and spirit would be healed from trauma as well. They agreed on the treatment and Lora paid for it to be undertaken at that very day.

Joana called one of her trainees (*thwasana*) to help with the *phungula* process and prepared the appropriate medicines to restore the Lora’s self and social projection (*xithuzi*). All the selected medicines were put in the boiling pot. Other medicines were prepared as well and put in a basin in order to be mixed up later with the water from (the “taking the bath” part of) the *phungula*. These medicines included most of the other elements (leaves and powder / *tinhunguvana*) excluding blood and minerals. Lora did the complete *phungula* aimed at cleansing and purifying the body-spirit (*Kuhlampsaxiviri*), heal the trauma of the relationship between the two, and restore her *xithuzi*.

This case is an example of how the *phungula* is used for the therapy *kuhlampsaxiviri* (purification, cleansing and healing).

5.2.3.2.2. Kubuyisa xiviri/ xithuzi (recovering the parted xiviri and healing the body-spirit)

5.2.3.2.2.1. João’s Phungula

The *kubuyisa xiviri* (recovering the parted *xiviri* and healing the body-spirit) can be documented by João’s case who was unable to hold down a job, who had lost his will, headaches, body pain and vertigo. (See Ch V, 5.2.2, Diagnosis). In that consultation the *nyamusoro* Adelia gave the solution (*nhlulelo*) of performing a *mhamba*¹⁷⁶ and, afterwards, recovering, purification, cleansing and healing

¹⁷⁵ From the verb *limpar* /to clean. Ronga and Changana uses have words from Portuguese.

¹⁷⁶ I describe this therapy called *timhamba* (plural) in the next section

of his *xiviri* affected by the problem of a disjunction between the ancestral spirits and his family and the *xisila* that came about.

João's completeness was jeopardised by the problem his family had with the ancestors. The *xisila* created was characterised by social rejection and misfortune. This directly affected his body-spirit and its projection (*xithuzi*). He was then victim of stigma because he did not have a job and, at the age of thirty two, could not sustain himself. People gossiped about him and looked at him with derision. This affected his social projection, identity, self and presence (*xithuzi*). The result of such harm was *kunyama* which is the reduction of the projection and trauma of the *xithuzi*. In indigenous medicine, cases like this are treated with *phungula*. The *phungula* for recovering the parted *xiviri* and healing the body-spirit (*kubuyisa xiviri/ xithuzi*) includes the purification, cleansing and healing *phungula* described in Lora's case (*Kuhlampsá xiviri*) but goes beyond it. It also involves different pharmacopeia and performative actions directed at the recovering process.

João's ceremony took place at his home and the nuclear family (his two brothers, three sisters and his mother) participated. After the communication with the spirits to reintegrate them, João's family and the ancestors were purified and cleansed with medicines. They were cleansed and purified because the spirits moved in improper contexts when they were displaced¹⁷⁷ and became impure and in turn the entire family became impure with *xisila* as well.

João was much more affected than the others members of the family because the ancestors found him responsible for their abandonment since he was the remaining 'older' brother. The relationship between his body and spirit was traumatised and his *xiviri* partly displaced with and by the ancestors in their "homelessness". The rest of the family were therefore only purified, cleansed and healed with

¹⁷⁷ Their paraphernalia and physical spaces allocated for them were destroyed.

a *phungula* (*kuhlampsa xiviri*), while the *phungula* for *kubuyisa xiviri* was performed for João in order to bring back his *xiviri* and connect it back to his body. The other part of his personhood needed to be completed by the reintegration of the ancestors. So, in contrast to Lora's *phungula*, when João was in the *phungula*, covered with blanket, the *nyamusoro* waved her Nguni *chovo*¹⁷⁸ to the north, south, east and west in different timing telling his *tinyanga* ancestors to bring back João with the aid of the medicines in the *phungula*. In each direction he also called João yelling João! João replied *whée*¹⁷⁹! And the *nyamusoro* said *buya halenu!* return back here! "*Buya, miri ni xiviri svaku svitlhangana sviva svitiya (...) uva ni xithuzi.* Return, your body and spirit must join together and be tight (...) you must have identity, self and presence."

João's entire family suffered from *xisila* (impurity; social restrictions and misfortune) and incompleteness of the relationship with their ancestors. João particularly suffered from *xisila* and a double incompleteness since his body and spirit were partly disjoined (*kupfa xiviri*)¹⁸⁰ and because his ancestors were homelessness. With the *phungula* for *kubuyisa xiviri*, the impurity, disjunction, trauma and affliction of him as an individual and in his relationships were adjusted, healed and cleansed.

Kubuyisa xiviri is not a static therapy but a dynamic one that depends on the causes that provoked the trauma in the relationship between the body and spirit. It is essentially a process of recovering the parted *xiviri* and healing the body-spirit in which purification and cleansing are important part. Yet

¹⁷⁸ Chovo – a *nyanga*'s tool made of gnu hair with a handle fabricated with appropriate medicines (see on photo 5 on page 145)

¹⁷⁹ Idiophone to reply to a calling by someone

¹⁸⁰ Note that people's incompleteness gradually starts from disjoining and their ability to project the *xiviri* socially (*xithuzi*) is reduced (*kupsha xiviri*), then comes *kuhunguka*, *kupepuka*, *kumphunta* and *kuhlanya*, which are degrees of disjunction, mental disturbances. The last one is a complete insanity, to go crazy.

purification and cleansing do not define *phungula* nor are they restricted to *phungula*. Purification and cleansing are performed in all other forms of treatments for *ntima* and *xisila* because they work to cleanse and purify the individual, family, community and their spaces.

5.2.3.2.3. *Kupfuxeta xiviri* and *Kutiyisa xiviri* (upgrading of the body-spirit and fortification of the body-spirit)

5.2.3.2.3.1. *Ananias' Phungula*

In my research I also followed histories of public servants in order to understand the therapeutic practice of *kupfuxeta xiviri* (upgrading of the body-spirit) and *kutiyisa xiviri* (fortification of the body-spirit). One of my informants, Ananias, was a police officer with the rank of Inspector. In October 2010 he was promoted to superintendent. He and around 40 other officers were graded in a public ceremony oriented by the Mozambique's president. On Saturday of that very week he went to see his *nyanga* Magaia in order to do the *kupfuxeta xiviri*.

Some of the medicines used in Ananias' *phungula* were different from the ones used in the cases described above. They were medicines more focused on upgrading and fortifying his *xiviri*. This requires two treatments performed in conjunction with one another; the upgrade serving to change the status of the body in order to match with the new identities of his *xiviri* (spirit) and *svithuzi* (social projection, personality) of superintendent, and the fortification, which is directed at building confidence and protection against misfortune and risks in Anania's social and professional life.

Ananias sat at a small stool, covered with blanket, the pan with the steaming *phungula* between his legs. Magaia then waved his Nguni *chovo* to the north, south, east and west in different timing asking his *tinyanga* ancestors and those of the patient to promote Ananias to his new identity of superintendent, make his body assume the new role with confidence, and strengthen relationship between the body and the spirit (*miri-xiviri*) in order to project an appropriate identity (*xithuzi*). The

patient stayed in the *phungula* for approximately 20 minutes. Magaia uncovered him and asked him to remain seated. He then took his hand and told him to rise with his aid. In the standing process Magaia said “(...) I am upgrading you body-spirit (...) as from today be strong and have the identity of a chief (...) do not be frightened by anybody and be competent in your work (...)/(...) *nhokupfuxeta xiviri (...) kusakela ka namuntlha utiya uva ni xithuzi xa hamba kufuma (...) ungachavisiwi hi ntirhu ni vanhu (...)*”.

Afterwards Ananias body-spirit was subjected to the process of fortification with the *kutlhavela* (vaccination). *Kutlhavela* is made using blade to cut appropriate parts of the head, arms, legs, thorax and back in form of two small ‘ells’ (ll) in which the *nyamusoro* puts medicines¹⁸¹. This phase compliments the *phungula* and they are normally associated. The fortification process actually starts during the *phungula*. Some of the medicines used in both are similar and form the link between the two phases. The symbolic – performative therapeutic strategies used by the *nyanga* in both phases are also similar. Together they bring about the changes both in the individual’s personal life and in their social capacity. In both the *phungula* and the *kutlhavela* the medicines are connected through the elements extracted from the animal, which in Ananias’s case was a sheep. *Phungula* uses parts sourced immediately after the killing of the animal, and the preparation used in *kutlhavela* involved *nhunguvana* (medicine crushed into powder) made from burned parts of the animal and its blood.

In Ananias’s case, before the *phungula*, which always precedes the *kutlhavela*, the sheep was killed by suffocation in water mixed with medicines. Ananias sat on the top of the sheep, and asphyxiated the animal in the water. Magaia guided and the *nyawuthi* (*nyanga*’s assistant) helped hold down the animal. The *nyanga* pronounces that the *xithuzi* (projection, identity) of the sheep has to join that of

¹⁸¹ This vaccination process has been pejoratively referred to as ‘scarification’ by a number of anthropologists.

Ananias and turn him into *hamba kufuma*¹⁸² (chief). The sheep is suffocated through inhaling the water mixed with medicines and, in the process, its identity and social projection is known to rise and merge with that of the patient. This symbolic - performative strategy engenders the change of the body-spirit and reshapes it into the new *xithuzi*. The symbols alone are meaningless without the 'performance' and medicines to engender the changes in health and social status.

The health and social 'will' Ananias needs in order to conduct his professional and social activities in the new contexts and situations are reshaped and informed by the medicines and symbolic – performative therapeutic strategies in the *kupfuxeta xiviri* and *kutiyisa xiviri*. The administrative authorities gave him new functions and symbols of superintendent and indigenous medicine upgraded his body and its relationship with the *xiviri* to the new status and identity.

These different therapies used to manage, fix, cleanse, upgrade, heal, and purify the body-spirit imply that personhood is mutable and changes over time amid the changes of one's social status and projection and that it is continuously reshaped through the manipulation of the relationship between one's body and spirit in health, wellbeing and identity formation. *Phungula* is a 'device' used to perform different therapies directed to bodies and individual spirits (*sviviri*). It is a part, not the whole, of these different therapies. Its relationship with the different therapies varies in relation to their type and purposes. It can be used *quasi* solely, as in the *kuhlampsa xiviri*, or in combination with other therapeutic elements as in the *kupfuxeta xiviri*.

5.2.3.3. The *timhamba*

As previously discussed, for many Mozambicans the living and the deceased ancestors are part of the same social world. When people die, their *sviviri* remain spiritually alive within the family and

¹⁸² Sheep is called *Hamba kufuma* means to lead.

community. The living have to reintegrate them back into society, and establish relationships with them as part of their composed and relational individuality. This engagement and social (re)integration can be the initiative of the living or demanded by the spiritual agents who can influence the living to comply with their demands. The social (re)integration and communication includes the performance of *mhamba*. The word '*mhamba*' designates all ceremonies in which the livings engage with their ancestral spirits. People perform this ceremony guided by four main motivations: (1) social reintegration of their deceased ancestors; (2) social reintegration, cleansing and healing of people and spirits exposed to *ntima* and *xisila* (due to trauma, death and bloodshed) as well as propitiate mourning and forgiveness; (3) building relationships and socio-cultural and political history; (4) and delivering requests to their spiritual agents for support, peace, harmony, prevention of misfortune and suffering. In the next paragraphs I outline some examples to document these different types of *timhamba* (plural).

The first two types of *mhamba* can be exemplified by João's case, (see 5.2.2, Diagnosis) in which his misfortune and social distress was diagnosed. The sources (*xivangelo*) of the problem were said to be the disjunction between him and his ancestral spirits. One of the solutions (*nhlulelo*) was identified as the performance of *mhamba*.

João's father's lineage (*kaya*) is Macandza and the matrilineal (*ka vakokwana*) is Chilaule. The Macandza held a *mhamba* in 1995, and for reasons I will describe, a second *mhamba* was required many years later, in response to João's diagnosis. Each *mhamba* served a different purpose and was therefore conducted in a different way. First I will describe the *mhamba* in 1995. It was diagnosed that the Macandza family and ancestors had *ntima* because the spirits from both the father's lineage (*kaya*) and the mother's (*vakokwana*) were never reintegrated and cleansed since they had passed away. The spirits from *kaya* involved his deceased father, grandfathers and the Nguni and Ndau

spirits headed by two *tinyanga* *Mapeje* and *Nyankwave*; a husband and wife who had been killed by João's grand grandfather (Peni) in the Nguni campaigns. These *tinyanga* became avenging spirits and came to the Macandza with Peny along with their parents and Nguni spirits and friends. They demanded to be reintegrated (as *vakon'ana*/grandsons) and be initiated to indigenous medicine (*wunyanga*). The spirits from *vakokwana* were João's mother's parents who had grown old and passed away in 1990 and 1992.

This 1995 *mhamba* was attended by João's brothers and sisters, his mother and his matrilineal and patrilineal relatives. His father had already passed away. Their family *nyanga* led the whole ceremony. João's oldest female relative (on his father's side) led the communication with the ancestors. She is the living *khosazana* ('communicator') who possess the power and authority in the lineage to communicate with the deceased in the *mhamba*. She also has the veto in the decisions that occur in indigenous ceremonies. The process took all day so the following account is a dramatically condensed version. First, the family went to the closest forest to bring the ancestors back home. It is symbolically assumed that the ancestors have been wandering in the bush, in forests and savannas since their death. They started the communication sequence by informing the deceased oldest female relative (the spiritual *khosazana*). They kneeled, put down snuff, wine, tap water, two chickens (male and female) and a number of *capulanas* of different colours as an integration gift and paraphernalia for the several deceased ancestors involved. The water symbolises the *phika* or *lihika* (request for forgiveness and healing of the ancestor's rancour). It liberates the ancestors from anger and gives the living the opportunity to acknowledge their mistakes. The deceased *khosazana* is asked to accept the reintegration gifts and paraphernalia and inform everybody down generations to do the same. The fellow ancestors to whom she is told to inform are classified according to hierarchy and kinship. The Macandza are the first and the Chilale the last in

the hierarchy. Chicken were then killed with a tree stem and roasted with firewood and eaten. Then they told the ancestors to come along home. The family got in the cars and sang appropriate songs all the way home. They stopped at the main entrance and those who had stayed at home came out to accompany them. They kneeled, put the snuff and wine alongside the *capulanas* placed on a plate and told the ancestors that this was their home, where they should live from that day on in order to stop suffering from the rain and the burning sun outside. They began another song and moved in to the first house (*dhumba*) built for the Macandza spirits. After placing them in the house, they told them that were going to place the Chilaule and the *vakon'wana* (sons-in-law) in their own *tindhumba* (plural), and did so.

They then proceeded to present a cow to the ancestors. They tied it to the tree that symbolises and shades the ancestors (the *gandzelo*), gave it medicines and after approximately an hour they killed it. João's grandfather and his elder sister killed the animal, holding the spear together to perform the ritual slaughter. Some content from the stomach was mixed up with blood and medicines to produce the cleansing and purification medicine (*muswanyu*). The entire family, the physical spaces they inhabit and their paraphernalia were cleansed from the *ntima* and *xisila*. This includes both the people and the spirits because, as previously discussed, the spirits are not voluntary producers of *ntima* but involuntary, indirect producers and victims. It is their death or the context of their death that provokes the *ntima* and harms them as well. The meat was cooked and the curry served with *wusva* (maize-meal). The meal was divided between the different lineages. In each lineage somebody was chosen to do the *kulumela* (ritual tasting).

Approximately 10 years after the ceremony, João's younger sister got married. The marriage took place at her parent's home. In order to create more space for the event, their elder brother (António) suggested they destroyed the ancestor's houses (*tindhombha*) which they would rebuild later

aggregated in one place. Their grandmother kneeled in each of the three *tindhombha* and communicated their intention to the ancestors. However, some time later, in 2006-2007 António got very sick with diabetes and with physical shock due to bankruptcy. He unsuccessfully tried therapy both at the hospital and with *tinyanga* and was eventually taken by his brothers-in-law to an evangelic church. With prayers and change in his social practices and experience (for example, abandonment of indigenous medicine and embracing Jesus Christ, breaking with 'traditional' marriages and establishment of brotherhood with the church members, etc.) he got better. As he was now in the Pentecostal church, he could no longer keep his promise of rebuilding the ancestor's houses. The ancestors were 'homeless' and, because of that, created misfortune within the family. Antonio fought their anger in the church with the power of Jesus and considered them manifestations of the devil. João was the member of the family most affected by the problem because, as explained, he was the appropriate person to be targeted by the *vakokwana* since he is named after someone within that lineage. This person/spirit (Samsone his *mab'izweni*) also had demands of its own. He wanted João to establish a more close relationship with him since he was already grown. João was also now the oldest brother left in the family because Antonio had joined the evangelic brotherhood. It may also have been just that he was the person who decided to pursue the solution more fiercely than others because of his health, and then became the *leitmotif* of the solution of the problem.

The family bought capulanas in order to replace the ones destroyed. They performed a small *mhamba* on a Sunday morning in order to have all the brothers and sisters present as they would not be working. His mother presented the capulanas to the ancestors from *kaya* (the patrilineal lineage, including the *vakon'wana*, sons-in-law) and to the ancestors from *vakokwana* (the matrilineal lineage). They used snuff and *phika*. Then João went to the *nyanga's b'andla* to do the treatment *Kubuyisa xiviri/ xithuzi* described above. This treatment recovered, purified, cleansed and healed his

xiviri affected by the problem of a disjunction between the ancestral and his family and the *xisila* that came about as a result.

In the two *timhamba* described above, people performed the social reintegration of their deceased ancestors. People share experiences with spirits in the same social environment. Their relationship is of dependence since they make up the same personhood and need one another. In the *timhamba* people and spirits are cleansed *ntima* and *xisila* (due to trauma, death and bloodshed) and healed from trauma, social distress and disharmony. The rituals encompass requests of forgiveness. The *mhamba* also represents appropriate mourning since it ensures the purity from dead and reunification between the deceased and the living. After the *mhamba* the social order is established and people return to normal life.

People communicate with the ancestors through *mhamba* for other important life events too, such as when they travel for long distances or time or when they pursue activities to which they think they need support from their ancestors. They also communicate with them to thank for successful activities and social achievements. Local authorities communicate with the ancestors when infrastructures such as schools and bridges are built. This simple and small *mhamba* is called *kuphahla mhamba* whilst the others described above in João's cases are called *kuba mhamba*. In *kuphahla mhamba* people communicate with the ancestors in order to request for support, peace, harmony, prevention of suffering, etc.

The situations in which people may communicate with their ancestral spirits in social practice are diverse. The *mhambha* embodies the social and cultural history of individuals, families and communities. During the *mhamba*, generations of ancestors going back into the distant past, are recalled. Due to this, and the types of social situations and events in which they are undertaken and

to their performativity, the *timhamba* make the events, memories and identities of the past become part of the present and keep them alive. Consequently, the *timhamba* make a living history in contrast to history as an intellectual endeavour. Its healing function assumes a broader meaning that encompasses treatment, prevention, and promotion of wellbeing, and builds social relationships and socio-cultural and political history.

The *mhamba* is a model of knowledge, experience and performance used for: social reintegration of the ancestors; social integration of the living, therapy, mourning and forgiveness of people and their deceased ancestors exposed to trauma, impurity, death or bloodshed; communicating with and delivering requests to spiritual agents for support, peace, harmony, prevention of suffering; as well as for building/representing relationships and social, cultural and political history.

5.3. Models of efficacy

Illness representation is strictly related to, and must be viewed in relation to, the therapeutic strategy for healing as well as to how and where this configuration works to engender transformation from illness to health and to alleviate people from suffering. Drawing on the section about health and illness, and therapy above, in the next paragraphs I will outline 'what heals', where and how. Unlike the biomedical concept of efficacy, which distinguishes efficacy (how specific treatments work in clinical controlled trial) from effectiveness (how a treatment works in medical practising), I looked into the efficacy of indigenous medicine in terms of the capability of its medicinal resources and medical interventions to produce a therapeutic effect (or failure) within contextual therapies. It was not the aim of this dissertation to evaluate the efficacy of indigenous medicine per se but to understand the models of efficacy. A model of efficacy is a form of representation of the ways through which the therapies are directed by those involved in the therapeutic encounter, in defined loci, using specific agents and strategies to engender changes from illness to health.

Previous studies of efficacy classified models of efficacy in terms of clinical, persuasive, structural and social support (Csordas and Kleinman's 1990; Levi-Strauss 1968; Turner 1967; Janzen 1978b). Among these models, only the persuasive and social support models are observable in indigenous medicine. The structural model locates the efficacy of body/emotion/cognition or person/society/culture. This structural view of the therapeutic encounter is static, universal and homogenous. Hence it does not account for the medical practices that take place in real therapeutic situations of indigenous medicine. The clinical approach focuses on singular individuals, illness, treatment and on definitive outcome, but the treatments and judgement of the outcomes in indigenous medicine do not focus on singular 'physical' individuals alone as this model suggests, but on body-spirits, groups and/or on their multidimensional and dividual relationships.

As aforementioned, I analysed the models of efficacy in terms of agents and strategies, loci and participants. The therapeutic agents and strategies are discerned beyond medicinal plants, symbols and physical bodies. Their therapeutic effect (or failure) is located in body-spirits, families and communities. The manoeuvre of therapy involves the *tinyanga*, spirits, patients, families and communities. In this context the models are phytotherapeutic, social support, and persuasive.

The phytotherapeutic model involves medicinal resources in their natural form, with or without the spiritual agency, symbols and performance of the *nyanga* to give them power. The locus of treatment and efficacy is the body-spirit of the patient. Examples are: the treatment of halitosis as seen in Jaime's case; the cleansing of the body-spirit and the relationship between the two, as in Lora's rape case where this is healed; the prevention of misfortune as in Joao's case of the fortification of the *xiviri* (*kutiyisa xiviri*); and the identity management in the upgrade of body-spirit (*kupfuxeta xiviri*) as seen in Ananias's case.

The social support model involves symbols, performance, and spiritual agency. These may or may not be combined with medicinal resources to achieve therapeutic effect. These always include a set of individuals, a family or community in the management of the therapy. The symbols, performance, and spiritual agency are directed at the patients and their groups (family or community) for the purposes of healing. The *timhamba* uses healing symbols, performance, medicinal resources, and spiritual agency to engender changes in family relationships, individual body-spirits and collective identities (*svithuzi*) in which the success (or failure) of the healing occurs in these multidimensional loci.

In the persuasive model, the *tinyanga* and spiritual agents use symbolic – performative therapeutic strategies and devices in order to engage with and control the mood and interests of the patients. The persuasion is directed to singular individuals or groups.

The persuasive, phytotherapeutic, medicinal resources and the symbolic – performative therapeutic strategies are the sources used not only to engender transformation from illness to health but also to prevent sickness, promote wellbeing, and build identities. Since indigenous medicine represents illness as a set of dysfunctions and abnormalities in the body, body-spirit, family, and community, separately or concomitantly, the healing or transformational power of these agents is located in this variety of loci. These different loci may have an arbitrary or dependent relationship with sickness. The models of efficacy are not mutually exclusive, in practice, but interrelated.

The management of the therapeutic instruments and the judgement of efficacy is controlled by the *tinyanga* in negotiation with patients, kin and communities. The *tinyanga* and their spirits are the ones who deliver the therapeutic devices or diagnose the type of therapeutic devices required and the way in which they have to be used. They can treat their patients directly or they can diagnose and, for

example, then tell them how to perform a *mhamba* to communicate with the ancestors in order to request for support, peace, harmony, and prevent suffering. The family and their lineages also get recommendations from the *tinyanga* on how to perform the *timhamba*.

5.4. Conclusions

The main objective of this chapter was to reveal the specific characteristics of indigenous medical practices. I focused on praxis and experience, and looked both at the way health, healing, therapeutic knowledge is represented in indigenous medicine, and its models of efficacy. The chapter argued for the need to rewrite the historiography of indigenous medicine, documenting its features, in order to build the foundations for debating illness representation in Mozambique. The ethnography described the essential interrelated and connected elements that form the basis of the representation of health and illness in indigenous medicine. Engaging critically with previous assumptions about the way indigenous medicine works, my ethnography revealed the actors and agents involved in the production and reproduction of health and illness, the local notion of personhood, the underlying categories of health and illness and the knowledge and experience of sicknesses, diagnosis, the healing process, and models of efficacy.

The main agents and actors involved in the therapeutic landscapes of indigenous medicine are the patients, *maziyon*, *tinyanga*, spiritual agents, local lineages and clans. The chapter focused on the *tinyanga* and spiritual agents since they are the main medical practitioners and who control the production and delivery of health knowledge. I examined their nature and professional training. Although their training is divided in integration and training events and in grading and legitimization processes, I only presented the training events. These served the purposes of the chapter and, the suppression of the grading and legitimization practices did not affect the treatment of the research questions.

In the description of the local notion of personhood I looked at the representation of what it means to be a person or individual, I brought into focus its internal and external elements, divisions, and boundaries and by doing so, I established the indigenous medical subject. Mozambicans are composite and relational individuals constituted by a body-spirit, spiritual agents, family and community. This personhood is controlled and regulated by the principles of harmony, commitment and influence between the people and the elements of the personhood and inform how people build up knowledge, experience and practice about the environment, their bodies, health, sickness and therapy.

In the description of the knowledge about and experience of sicknesses, diagnosis, therapy, and models of efficacy in indigenous medicine, I firstly outlined the indigenous medicine typology of illness and the model of sickness in relation to its aetiologies and personhood. I also analysed the tools and strategies used to diagnose sickness, which includes diagnostic tools and techniques of communication with spiritual agents used by the *tinyanga* in negotiation with patients. In the section on therapy I presented the agents and strategies that indigenous medicine uses to engender transformation from illness to health. I examined the pharmacopeia and the symbolic – performative therapeutic strategies. These therapeutic tools and agents are applied to engender transformation from illness to health, prevent suffering and promote wellbeing. I finished the chapter outlining the models of efficacy relevant in the representation of the ways through which the therapies are directed by those involved in the therapeutic encounter, in defined loci, using specific agents and strategies to engender changes from illness to health. These models are phytotherapeutic, social support, and persuasive. They are intertwined and interrelated and only serve for heuristic purposes.

CHAPTER VI: THERAPEUTIC LANDSCAPES IN MAPUTO AND MANHIÇA: HEALTH DELIVERY AND CHOICE

6.0. Introduction

This chapter analyses the therapeutic delivery and choice in Maputo and Maluana. It focuses on the features of the therapeutic landscapes as well as on the way in which the patients and health practitioners experience, deliver and choose them.

The availability of different forms of health provision for bringing about or maintaining health provides options to patients to choose from a variety of therapies. Therefore, when searching for health services patients must make decisions regarding the favourable choice among the existing medical practices. This chapter is interested in responding to the questions: what forms of health provision are available in the context? What meanings are associated to them? And what contextual factors influence or determine their choice?

My main argument of the chapter is that Mozambique's therapeutic landscape encompasses health and healing knowledge, practices and experiences from different medical traditions, which give people different opportunities to strategise and manage their health problems and to pursue for maintaining wellbeing. The Official National Health Services (ONHS) is an imagination of those in control of the State health delivery because, being exclusively biomedical, it does not account for all the health delivery and choice available in the context of the real therapeutic choices being made by the majority of Mozambicans. Patients undermine the ONHS through representing, legitimising, and seeking for therapy simultaneously in the variety of medical practices within the Contextual National Health Service (CNHS).

In Manhiça, I focused the analysis of the therapeutic choice in Maluana and Calanga administrative Posts. In Maputo city, I observed therapeutic experiences from the municipal districts KaMaxakeni,

Kampfumu, Kamabukwana and Kamavota. These locations are names as such for the purpose of reference, however, as previously stated, the actual boundaries of health networks are geographically blurred as they are socially and culturally located.

6.1. Where do people go when they feel sick?

Maluana is on the national highway number 1 (EN1) and is a typical small rural village with some modern facilities, such as shops and a health post along the highway. Much of the area covered by the Maluana health post is only accessible by a 4x4 vehicle and many people live far away from the facilities. This Administrative Post has two *localidades* (localities), Maluana Sede and Munguine. Inhabitants say that the name Maluana was given by the Portuguese colonisers and although it was maintained by the post-colonial State, they call it interchangeably Maluana and 'Xirindza'; the surname of the local traditional authority (the *Rainha*, or 'Queen'). Maluana is both an administrative post and a chiefdom. The Chief of the post represents the State administration and the Queen rules all cultural affairs. This is not as simple a division of authority as it might seem since there are some ambiguities in relation to power, authority and the position of the State.

Maluana is a poor rural area. The main activities are subsistence agriculture and animal husbandry, and the collection of firewood and production of charcoal for sale on the EN1, in Manhiça Village and Maputo City. The main source of livelihood is agriculture. It has 21,537 inhabitants and 4,202 families.

Calanga, the second administrative post in my analysis, is, on the other hand, an isolated poor region separated from the rest of the district by the Incomati River and valley. There are no modern facilities such as public transportation, 'modern' technology¹⁸³, and urban constructions. The main road to

¹⁸³ Except mobile phones and very few radios and solar panels.

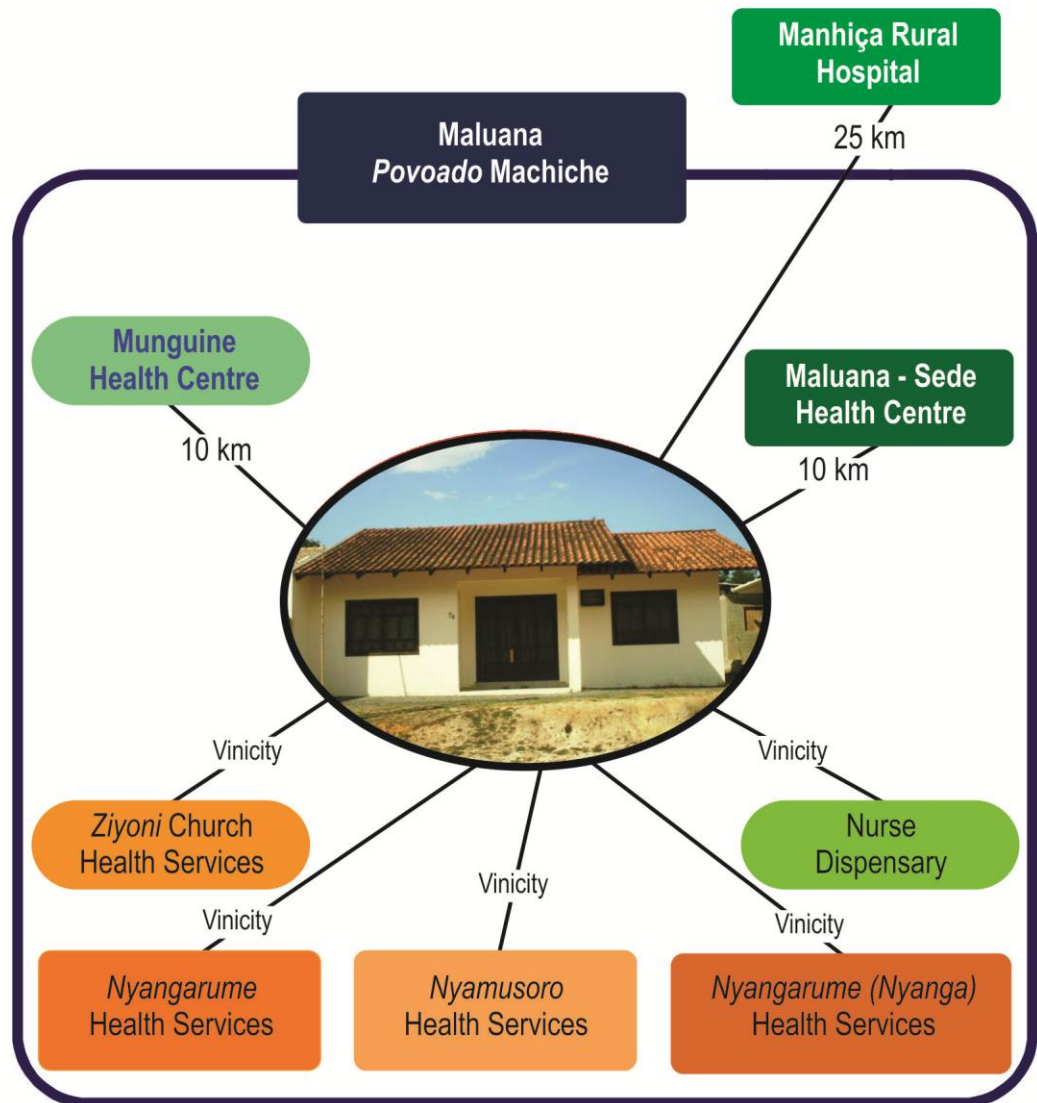
Calanga crosses the 30 km of the valley all the way down to the post. It is not paved and ends at the chief administrative building, beyond which there are no roads, only tracks between the households and sources of water and grazing and no state administration. Calanga also has two localities, Checua and Lagoa Phati. The estimated population of the two combined is 13.967 inhabitants, 2.500 families. The main activities are agriculture, apiculture and local beer trade. The main source of livelihoods is agriculture. A few families have relatives working in Maputo City who send food for their survival.

In colonial time the State administration in Calanga was entrusted to traditional authorities *Régulos* (for *povoações*) and *Chefes de Terra* (for *povoados*)¹⁸⁴. As in Maluana, after independence the traditional authority was replaced by the secretary of the Party. These traditional authorities were re-established and returned to power after the introduction of the multiparty democracy and the collapse of the FRELIMO single party rule. Their authority was legally recognised again in 2005 with the law 8/2003 & the Decree 11/2005 regulates their incorporation into the 'State administration'.

The diagram below depicts the therapeutic landscape of Maluana and Calanga and show where people go when they seek therapy in these two communities. Both administrative posts are located in the same district and, consequently share the same district infrastructures.

¹⁸⁴ Mozambique is geographically divided into provinces, districts, and administrative posts, subdivided into localidades¹⁸⁴, *povoações*¹⁸⁴ and *povoados*¹⁸⁴. (see Chapter III),

Figure 7. Therapeutic landscapes in Maluana



In Maluana people consult four types of health services when they are ill or suffer misfortune. The biomedical health services, and the indigenous health services of the *tinyanga* (*vanyamussoro*), the *tinyangarume* and the Ziyoni Church.

The Health centre of Maluana is in the vicinity of the headquarters of the Administrative post and between 10 – 15 Km (6 – 10 miles) from the centre of the communities. It has nurses and birth attendants. Munguine health post is at the centre of Munguine chief locality and has a nurse who

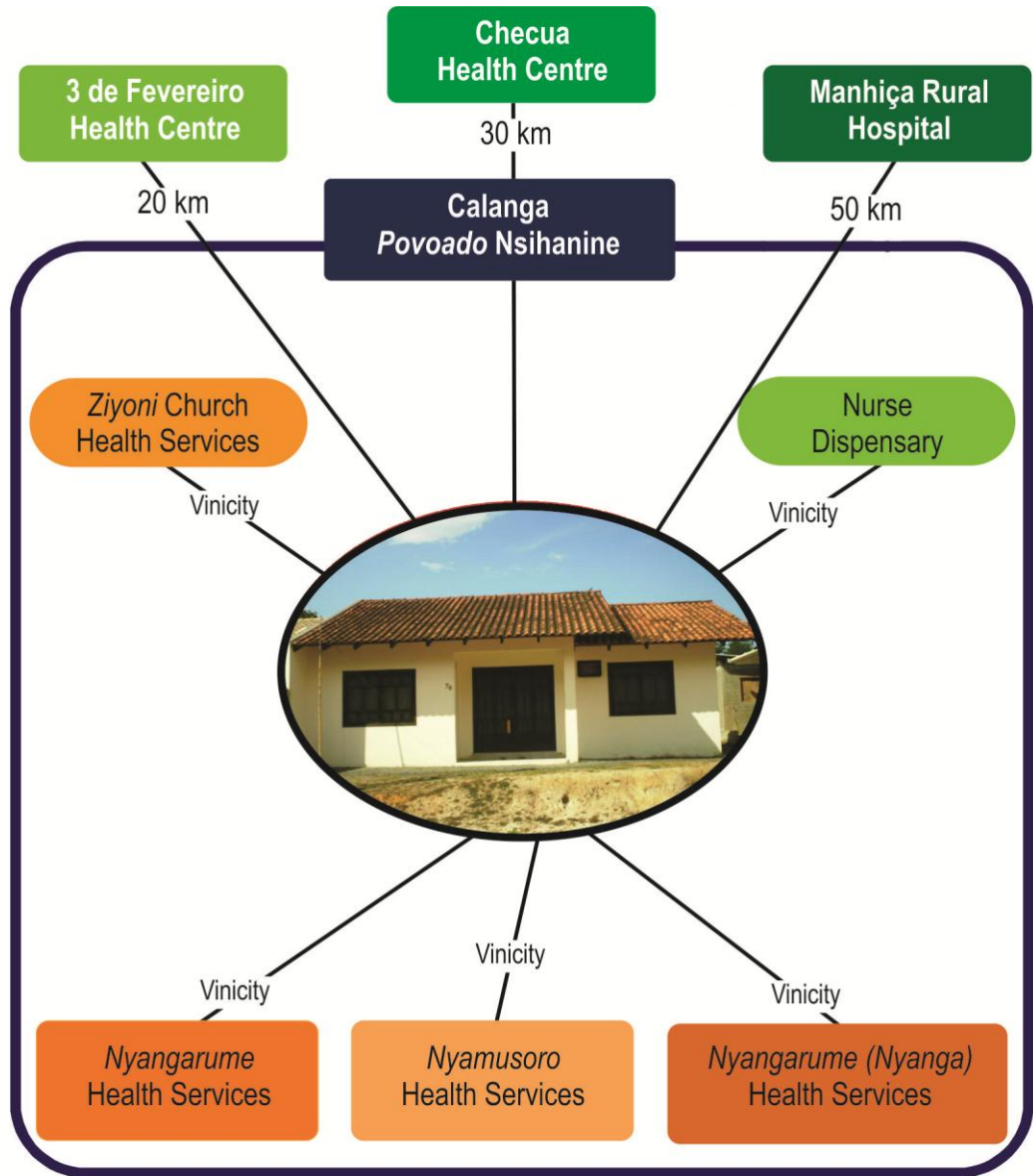
mostly serves the local community. The rural hospital of Manhiça has biomedically trained doctors and nurses. It is 25 - 40 Km (16 - 25 miles) from the dispersed communities of Maluana. The two '*postos de agentes polivalentes*' (nurse dispensary) in the vicinity do not have trained nurses but instead have an '*agente polivalente*' (polyvalent agent) who is responsible for a number of community health tasks and, according to the residents, is rarely provided with medication to deliver therapy. The other health services, provided by the Ziyoni church, the *tinyangarume*, and the *tinyanga*, are accessed locally and equipped with indigenous medicines to deliver therapy.

The therapeutic landscape is different in Calanga. Here people attend the same four types of health care services, namely, the biomedical health services, and the indigenous health services of the Zion church, the *nyangarume*, and the *nyamusoro*. The biomedical services are available at two health centres and the same rural hospital at the Chief District of Manhiça used by the communities of Maluana. The health centres, one located 20 Km (12 miles) and the other 30 km (19 miles) away, are each served by a nurse with some basic nursing training, and a birth attendant. The nurse deals with local non severe pathologies, surgical problems, child vaccination and so forth. The birth attendant attends non complicated childbirth as defined by the biomedical standards. For example a 40-year-old expectant mother would be referred to the rural hospital which is located 50 Km (31 miles) away where there are biomedical trained doctors, nurses and other workers.

Calanga has no public transportation to the urban facilities and services and due to its isolation, other transportation, even bicycles are rare. People therefore walk to access any biomedical therapy. As in Maluana, the nurse dispensary in the vicinity does not have any nurses but rather a polyvalent agent with extremely limited materials or medications. People therefore hardly ever go there and, when in need of biomedical services, they seek therapy at the rural hospital 31 miles away. The remaining

health care services of the *Ziyoni* church, the *nyangarume*, and the *tinyanga* are found in the vicinity and as in Maluana, have access to indigenous medicine in local ecology.

Figure 8. Therapeutic landscapes in Calanga



For most Calanga residents, it's a long walk to a nearest health centre. From Chihau for example people walk 30 km (19 miles) to the local health centre at Checua, 50 Km (31 miles) to the rural hospital situated in Manhiça; and 20 km (12 miles) to the '3 de Fevereiro' health centre. As elsewhere

the nurse dispensary in the vicinity has an untrained polyvalent agent with extremely limited medications to offer their patients. As in Maluana, the Ziyoni church, the *tinyangarume*, and the *vanyamusoro* health services are easily found locally.

In both Maluana and Calanga *vanyamusoro* refer their patients to *nyangarume* and vice-versa, and both refer patients also to the biomedical health services. In some instances biomedical services also refer patients to indigenous counterparts for certain types of sickness that local biomedical practitioners associate with indigenous aetiologies. This mutual referral is rooted and motivated by local social and cultural factors. Importantly, in Maluana and Calanga the Ziyoni health services refer patients to the *nyanga* and *nyangarume* health services but the reverse does not happen very often. The reasons behind this were described in chapter V.

Maputo City is the capital of Mozambique and the largest city in the country. It has an estimated population of around 2,000,000 inhabitants. It is administrated by a Municipal Council headed by a Council President. As the capital of the country it enjoys benefits from infrastructures and urban facilities. These consist of several public and private hospitals which include the Maputo Central Hospital; a centre of national reference for complex biomedical therapies. Public and private transportation is also available.

Like cities in many non-industrialised countries, Maputo has social problems such as poor sanitation, poverty and unemployment. The biomedical health sector's efficacy is jeopardized, *inter alia*, by the low State budget 50% of which is dependent on external donors¹⁸⁵.

The gap between the rich and the poor is alarming. The majority of the population live on less than a pound sterling equivalent per day. The middle class is diversified, much of their incomes and benefits

¹⁸⁵ <http://www.govmoz.gov.mz/parpa/eindex.htm>

deriving from the multinational companies operating in every sector of the economy. The income of the rich is largely from multinational business, political corruption, crime and fiscal evasion. Health seeking and provision has to be understood within this context and social strata.

The therapeutic landscapes of Maputo are not represented in the schema due to their complexity. In Maputo people have more biomedical therapeutic options than in Manhiça. In every neighbourhood (*bairro*) they have access to hospitals, and to the Zion church, the *tinyangarume*, the *vanyamusoro*, and Chinese health services. The latter are located in the centre of the town and all the others are found scattered throughout the city and its suburbs and neighbourhood *bairros*.

6.1.1. Social change in the therapeutic landscapes

The table below summarises the common health services in Manhica and Maputo before 1986 – the end of the revolutionary system and the beginning of the neoliberal capitalist model of structural adjustment and ‘western’ democratization.

Table 7. Types of ‘traditional’ Health Services and Provision

Types of Health Services and Provision		
<i>Nyamusoro</i>		<i>B’andla</i> : The health service of a trained spirit medium, delivering therapy typically based on rituals, mediumship, and indigenous medicines from the animal world, minerals, herbs and hydro-products.
<i>Nyangarume (Nyanga)</i>		<i>B’andla</i> : The health service of a trained health practitioner, who, different from the herbalist <i>tinyangarume</i> , also diagnoses with <i>tinhlolo</i> – diagnostic tools, and delivers remedies based on indigenous medicines from the animal world, minerals, herbs and hydro-products. Usually, specialises in a repertoire of sickness.
<i>Nyangarume</i>		<i>Ka Nyangarume/bamuri</i> (place or who heals by remedies): The house of one providing remedies based on indigenous medicines from the animal world, minerals, herbs and hydro-products. Usually, specialises in healing one, two or three diseases.
Zione	<i>Nyangarume</i>	<i>Ka bamuri/Nyangarume</i> (place / person for healing by remedies): The house of one providing remedies based on indigenous medicines from the animal world, minerals, herbs and hydro-products. On the contrary to the type above, this is rooted in the Zion church and epistemology. Provides services at home or at the church.
	Prophet (<i>muprofeti</i>)	<i>Kerekeni</i> (the church): Of the Zion therapist who diagnoses through god and ancestors’ inspiration, delivering therapy typically based on prayers, rituals, and indigenous medicines from the animal world, minerals, herbs and hydro-products. Typically a priest but not necessarily.
	Spirit medium (<i>Muxokari</i>)	Spirit medium. Performs diagnosis through god and ancestors’ inspiration. Sometimes delivers therapy typically based on rituals, indigenous medicines from the animal world, herbs, minerals and hydro-products. Provides services at home or at the church.
Biomedical Hospital		Typical biomedical hospital. Central Hospital of Maputo, general hospitals in Mavalane, Machava, Jose Macamo, etc. Several health centres and posts. Military hospital. All in Maputo. And the Rural Hospital in Manhica. Health centres, and Health dispensaries (Calanga and Maluana). Provide biomedical therapies and surgeries.
Indigenous medicine shops		These shops sell indigenous medicines and are located in the markets (Manhica and Maputo), and domestic shops and <i>barraca</i> in Maputo. They are owned by the <i>tinyangarume</i> , <i>vanyamusoro</i> , the Zion, ‘herbalists’ specialising in indigenous medicine harvesting and commerce.

Types of Health Services and Provision	
Pharmacies	Pharmacies which sell essentially biomedical pharmaceuticals. They have trained pharmacists. Some are State and others are privately owned.

The liberalisation of the economy which started in the 1990s forced the liberalisation of health services and enhanced the proliferation of the private health sector to counteract the socialist centralised health services. The state ONHS remained the main biomedical health provider but in cities all over the country, especially in Maputo, private clinics emerged. This liberalisation did not only impact on the ONHS but on the entire CNHS. New forms of therapeutic landscapes have also emerged in the health field.

Indigenous medical practice has embraced the mercantile logic of the post-colonial capitalist era and became more profit oriented. The *tinyangarume*, the *vanyamusoro*, the *Ziyoni* Church and biomedical private and public hospitals now compete with each other for clients, control of their patients and maximisation of incomes. They have been modernizing and producing new therapeutic strategies, innovations and representations to accommodate internal and external elements with add value into their health provision and ability to compete in health delivery. Pharmacies and indigenous medicine shops have multiplied and started prescribing not just selling medicines. In these new landscapes patients develop knowledge about which circumstances and for which ailment they should go see doctors, *tinyanga*, pharmacists or indigenous medicine sellers (commonly called '*ervanários*'). Amid the availability of pharmacists and *ervanários*, who prescribe and supply medicines, patients attempt to avoid paying the services of the 'traditional' health practitioners, biomedical doctors, *tinyanga* and *maziyoní*. For example, on one of my visits to a pharmacy during my fieldwork in Maputo, I coincided with a lady who was going to purchase medicine for malaria prescribed by a doctor. She could not afford that particular medicine. The pharmacist recommended a different and cheaper

pharmaceutical which he said had the same chemical and healing capacities. He also prescribed her painkillers that were not on the doctor's prescription saying that doctors should have done this. In the observation I made at this pharmacy and others in Maputo three among five clients did not have prescription but presented their health signals and experience to the pharmacist who medicated them.

The *ervanários* also prescribe indigenous medicine. Different from the high street pharmacists they sell/supply medicines to the *tinyanga* - especially in Maputo where there are no forests and thus no source of herbal products. *Tinyanga* are their major customers. Almost all patients that go to the *ervanários* are not sent by the *tinyanga* because the *tinyanga* diagnose and heal with their own stock of medicines.

By dismissing the hospitals and relying on and seeking prescriptions from pharmacists and *ervanários* patients also take control of their bodies in the representation of certain types of sickness, creating new health spaces and networks. They also diversify the knowledge and choice of health delivery.

As a consequence of the liberalization of indigenous medicine, change of its official status with the declaration of the traditional medicine policy, increased discourses on the promotion of indigenous medicine, and of the lack of regulatory procedures to unify its provision, indigenous medicine expanded its forms of delivery. New types of indigenous medical practitioners from neighbouring countries and the north of Mozambique flourish in Maputo advertising new products and therapeutic opportunities (see photo 11 below).

Photo 11. Adverts of New forms of indigenous medicine



These forms of indigenous medicine are considered exogenous by the locals and are still struggling for recognition. Local discourses from the *tinyanga*, biomedical practitioners and general public cast them as disreputable because they advertise in newspapers and street panels as offering new therapeutic opportunities for phenomenon that break out the local (indigenous) medical boundaries, for example, increasing the size of penis and vagina, or improving learning or memory. Neither typical endogenous indigenous medical practitioners nor biomedical services advertise their health services. The former are forbidden by internal principles in which the reputation of the *tinyanga* (spirits and *ligodo*/therapist) to work is demonstrated, judged and represented by its ability to provide services without publicising them. It is the efficacy of their health provision and capacity to attract patients that grants them authority. Biomedical services are legally prohibited to publicise the types of illness they heal.

However these new forms of exogenous indigenous medicine have been competing fiercely to integrate into the local landscapes. The first type of these '*tinyanga*', who started advertising in

newspapers early in the 1990s, were generally rejected in Manhiça and surrounding neighbourhoods of Maputo, which are strongholds of 'traditional' biomedical and indigenous medicine services, but people had diverging opinions and visited them in urban Maputo. Manhiça and surrounding neighbourhoods of Maputo had tight social networks, strong cultural identity and a slower incorporation of 'modern' and liberal practices, whilst urban Maputo is more liberal and exposed to different social networks and cosmologies. This explains the regular presence of *tinyanga* in newspapers for the last 20 years.

There is rivalry between the typically exogenous forms of indigenous medicine, biomedicine and the typically exogenous forms of indigenous medicine accentuated by the fact that some health providers are 'hidden' while others are exposed to the clientele and choice. The new forms of exogenous indigenous medicine take advantage of popular publicity mechanisms. For example, one such '*nyanga*' of this type called Sofrimento Lingore has been advertised uninterruptedly in *Savana* newspaper every week since 1994¹⁸⁶. The *tinyanga* and medical doctors I interviewed and those interviewed on local radio and television argue and question whether this is ethical¹⁸⁷.

The majority of *tinyanga* I interacted with and interviewed call the exogenous healers charlatans, and others make fun of them. Others still do not identify themselves with their medical culture. However some people, including some of my informants, mainly in urban Maputo, showed interest with their types of health provision (in boosting sexuality, business success, educational achievement, skills, etc). It can be inferred that some patients see these new types of health providers as less disreputable, and their expertise and idioms are already integrated into local therapeutic landscapes.

¹⁸⁶ *Savana* is a nationwide newspaper issued every Fridays

¹⁸⁷ See also Felisbela 22/08/2012, TVM, Interview.

The offers of unusual health therapies by the 'exogenous' forms of indigenous medicine can be seen as a strategy to extend their repertoire of health practices, create exclusivity, and position themselves in a particular segment of the health field.

Maputo medical landscapes now also encompass Chinese and Indian indigenous medicine (mainly acupuncture, naturopathy and ayurvedic). My research did not get in-depth ethnographic material of the way these new forms of health provision operate. However, during my work with their practitioners within the last 10 years I have noted that they are used mainly by foreigners, and middle class or high income elites.

Taking into consideration the existence, utilisation and persistence of the current medical opportunities within the context, and the phenomenon of social change, analytical inquiry shall soon question the notion of 'exogenous forms of indigenous medicine' that I have been using so far. Its use may therefore need to be readdressed in the future.

In the next sections I analyse the factors that attract patients to a specific health service or therapy within the therapeutic landscape.

6.2. Therapeutic choice

6.2.1. Symbolic Capital

The use and provision of health services in Manhica and Maputo depends on the strengths of the various forms of capital held by people. This capital includes the types and forms of illness representation and the knowledge about these, as well as the capital of social relationships.

6.2.1.1. Illness representation and knowledge

In the perspective of the patients there is a repertoire of illnesses caused by different factors. To mitigate these illnesses patients search for therapy from the different dimensions and networks of the health fields within the health providers and knowledge on health available to them. These do not all provide the same kind of therapy, nor do they have the same practices and worldviews on health. The representation of health/illness varies from one type of health care service to the other. For example, for the *nyamussoro*, illnesses can denote abnormality in the functioning of bodily elements; a disjunction between the elements of the body – spirit, disharmony with the spirits or a violation of the social and ecological norms. Any therapy will be directed to harmonise the functioning of bodily elements, to mediate and reaffirm cohabitation between the spirits and the living; or to restore the observance of the ecological norm violated. In the next paragraphs I will present some cases and encounters that portray how this works.

6.2.1.1.1. Maria's Case

Maria from Maputo had a sickness called *xilume*. Since this illness jeopardizes female reproduction - one does not get pregnant - she was about to 'lose' her husband who was planning to marry another (reproductive) women. In Maputo as elsewhere in Mozambique reproduction is a pillar for sustaining marriages. There was a consensus with her husband that she would seek treatment for infertility.

"I knew that there was no treatment for *xilume* at the hospital (...) that is why I have decided to seek therapy at the *tinyanga* (...) she is a *nyangarume* (...) a good one ... I was told by a friend who had the same problem (...) I went looking for her and two months after the treatment I got pregnant (...) now I have a boy and two girls (...)"¹⁸⁸

¹⁸⁸ Maria x Research consultant/ informant from Maputo

Maria did not try biomedical therapy despite the fact that Maputo has several hospitals around. Her assertion that locates the treatment of *xilume* to indigenous medicine is not trivial; conversely if we take *xilume* seriously we find that it does not appear in the biomedical list of diseases. The illness is not conceived of in biomedical terms and its aetiologies lie in indigenous medicine principles and classification. It can be *Xilume xa duna* (male *xilume*) and *xilume xa wansati* (female *xilume*). The former means complete infertility. i.e. people with *xilume xa duna* do not get pregnant whereas the latter leads to early abortions. This illness is classified in terms of gender, which is intrinsic to the indigenous medicine taxonomy. Plants and other medicines are also classified in terms of gender. (see Chapter V). A *nyangarume* explained to me:

The treatment of *xilume xa duna* requires a combination of different remedies including *mhangana*/aloe and X (...) these are the main ones (...) you need to combine both male and female in order for the therapy for *xilume xa duna* to be effective (...)”¹⁸⁹

The knowledge about sickness and its representation lay within the same gendered system as that of the medicines and the therapeutic practices used to alleviate the suffering. They are rooted in the same health epistemology and practices. This was discussed in the section about therapy in Chapter V.

Maria was aware of the type of health care services that could solve her problem and, according to her, it was the *nyangarume* who actually solved the *xilume xa duna* she was suffering from. Male and female *xilume* are commonly reported in the south of Mozambique. People usually make judgements and decisions to use a specific health service and therapy according to the repertoire of illness that it treats (Belliard & Ramirez-Johnson 2005; Jimenez 1995; Janzen 1978b).

¹⁸⁹ *Nyanga Jauliza – Manhica.*

6.2.1.1.2. Felomena's Case

Felomena's husband got ill and they decided to go to the hospital. The hospital diagnosed renal failure and he was told that no cure was available for that bodily illness. They gave him some tablets to alleviate the pains. He was not content with the "no cure" prescription hence he started looking for therapy at the *nyangarume* health services. A *nyangarume* gave him medicines, a combination of *timpande* (roots) and *matluka* (leaves). However, the treatment did not succeed after a month; "actually things got worse"¹⁹⁰.

"For that reason my husband and I decided to look for another type of *nyanga* to treat him and we ended at an elderly male *nyamussoro*. He made a diagnosis and recommended a *kufemba* health practice. He said that before the medication we should talk to the ancestors (...) they wanted to talk to us (...) they were contributing to the unsuccessfulness of the therapies (...). The *nyamusoro* exorcised things from his body and called our ancestors who spoke to us (...).among other things they said that we should try the hospital (...) but 'combine' the biomedical therapy with indigenous medicines".

The *nyamusoro* co-medicated Felomena's husband with a combination of five medicines but he did not recover and passed away at the age of 44.

This case shows a concatenation of factors influencing the therapeutic choice. The family's view was that the patient's illness could be healed at the hospital. But when the hospital could not help, they continued to understand that the sickness was due to a bodily abnormality, and then that the *nyangarume* could also be the source of expert knowledge and therapy. Why did they go to the *nyangarume* before seeing the *nyamussoro*? Felomena said that they did not start by seeking therapy from the *nyamusoro* because they were Catholic and so had not used indigenous medicine before. In addition, she said that for a long time it was forbidden by the *nawu wa fumu* (State norms)

¹⁹⁰ Felomena's statement

to consult the *tinyanga*. The choice of therapy is associated with the way this family relates the body to the sickness and its experience is thus mediated between the troubled history of “medical pluralism” in the country and their cultural (religious) principles based on the bible and a supplication to a monotheistic god rather than ancestors¹⁹¹.

The progress of his illness obliged them to decide on different therapeutic options and reframe their relationship with local knowledge and expertise. They went to see a *nyamusoro* for therapy. It was explained to them that spirits were involved in the problem and were co-agents in jeopardizing Felomena’s husband’s health. But the ancestors confused, mixed and blurred the responsibility of the therapy of the *nyamusoro* recommending that it should be complemented by biomedical services. The therapy still did not work and when he was sent back to the hospital he passed away. The hospital was eventually returned to as the last resort. It is often seen as a place where people should go when no other therapeutic option is available or works, and has become an ‘authorised’ place to send the terminally ill.

The cases and discussions above are associated with a common discussion in Mozambique’s health field about who should control the sick. It is argued that “(...) the *tinyanga* hold the patients trying to heal them, without knowledgeable therapies, and send them to the hospital when it is already too late (...)”¹⁹² – Gaspar (2012). Who decides who can heal and who cannot? People die with the *tinyanga* the same way they do at hospitals. The *tinyanga*’s decisions may have negative health effects but this is neither a consistent experience, nor one exclusive to *tinyanga*. Both *tinyanga* and biomedical doctors fail to heal at times despite their best efforts, knowing on some occasions that they do not

¹⁹¹ It is important to note that many Catholic people used to consult indigenous healers even during the Marxism era. Hence we should not homogenize this view to the entire catholic community.

¹⁹² Felisbela Gaspar, Director of the IMT, interview 22/08/2012, TVM

have the required expertise to achieve efficacy. All are healers trying to treat people; some more supported and resourced than others. The way they treat patients, as well as the condition in which they produce, deliver and succeed or fail with their healing and efficacy has to be historically located, and is culturally contingent. Felisbela's ideas have little to do with questions of intrinsic efficacy of indigenous medicine and biomedicine per se but with claims of power and attempts to occupy positions in a context of competing healing practices.

People also choose a certain health care service because it upholds unique therapy expertise. As one informant explained to me in Maputo, "*Atinyanga ativacheli ngati vanhu (...) svafana ni mati aticheli* / the *tinyanga* do not inject blood or water if one's sickness does require". For example, Joana fell sick and her mother and sister decided to take her to the hospital since they suspected that it was "lack of water in her body". Accordingly, they walked for 20 km (12 miles) from the *povoação* of Chihau in Calanga, Manhiça to the Checua health centre. The Centre did not have expertise to diagnose the problem and referred them to the rural hospital of Manhiça, 50km (31 miles) away which diagnosed malaria. She walked home two days later, her life saved. They gave her tablets for three days and injected her with quinine. Joana and her *therapy management group* knew the appropriate health service to consult despite the distant location. The choice of that specific health care service was influenced by the uniqueness of therapy it provides and the way patients read the signs and symptoms of malaria. The expertise and reputation of biomedicine to manipulate and inject liquids in the human physical body influences the patients in deciding to use it.

Similarly, there are some indigenous illnesses that the biomedical health services do not deal with such as the *Ntima*. For example, ex-soldiers and widows and widowers rarely accept to continue living in their community or family without cleansing, purification and restoring their social projection, identity, self, presence (*xithuzi*), and junction of the body-spirit (*xiviri and miri*). Former soldiers from

the civil war in Mozambique underwent indigenous therapeutic procedures for *ntima* (see Granjo 2007, Honwana 2002).

When Zafanias's wife from Maputo died, he also underwent the therapy to heal the *ntima* and restore his *xithuzi*. He chose a *nyamussoro* to provide the remedies for the ritual of purification,¹⁹³ which involves sexual intercourse with someone of opposite sex and remedy-based cleansing process.

“After sexual intercourse, our bodily fluids¹⁹⁴ become an essential part of the purification ritual. They were mixed with remedies and the product was used to cleanse the environment (...) my household (...) and myself”¹⁹⁵

Sexual relations are undertaken to socially re-integrate the widow or widower. If this person is to have sex with another prior to this ritual, they are considered vulnerable to infection by *nkohlala*¹⁹⁶. This cultural norm reinforces the construction of illness and influences the delivery and choice of therapy. The knowledge of and about *ntima*, the expertise to heal it, and the cultural competence to weave in the health field are the main capitals that influence the therapeutic choice.

6.2.1.2. Social relations

The people we know or have a relationship with are social capital because this relation can help us find and use adequate therapy. The right *nyanga* and therapy to use can be accessed through networks of relatives or friends. *Tinyanga* are known to others during the therapies they provide within the families, or are shown by the parents or elders sisters and brothers. For example, the

¹⁹³ This is similar to the sororate (Kottak 2000) – a social practice by which a widower marries the sister of his deceased wife. However, in the research sites this practice is rarely made between relatives.

¹⁹⁴ Semen and vaginal fluids.

¹⁹⁵ Zefanias, Maputo. July of 2011.

¹⁹⁶ Something similar to tuberculosis

medicine for infants - *wheti* - is normally taken from trusted family *tinyangarume* or *vanyamusoro* who are believed to deliver efficacious medicine and whose spiritual agents are known to match with the patient's ancestors. Indeed, people even cross provincial borders to collect medicines from their family *nyanga*. Patients also get information about the *tinyanga* that suit their health needs from colleagues and friends. Since talk about indigenous medicine does not open in public or in formal conversations, the information about indigenous healing matters undergoes tacit agreements between the participants (friends, colleagues and relatives) in informal conversations and may require skills from the seeker to solicit information.

Since the *tinyanga* do not publicise their services but are just known in the neighbourhood and by networks of patients, young patients whose parents question indigenous medicine, such as those of evangelists and of those who inherited colonial attitudes, find it harder to access indigenous health knowledge and networks that would have normally been transmitted by their parents. Other forms of social networks, such as friends and partners, play an important role for this group to know the right ways of seeking for *tinyanga* and influence their access to therapy and relief of suffering. For example, a number of young patients I observed during my research, especially of female gender, were shown or went along to see the *tinyanga* with their friends¹⁹⁷.

Very often it happens that the decision to attend a certain health care service is rooted in the kinship structure because the illnesses and the related therapy goes beyond the sufferer and affects the entire family. The realm of the ancestors, that are a part of the aetiologies of health/illness, involves both the matrilineal as well as the patrilineal side, as one informant asserts:

"I cannot go to the *nyamusoro* for diagnosis alone (...) it is necessary that I go with my wife (...) what if the rituals are from her ancestors? She also needs to attend the diagnoses. Similarly, she should

¹⁹⁷ The fact that I observed mostly women does not indicate that men do not do the same.

not go alone since the illnesses and its solution may be located in my ancestors (lineage)” - X Matlombe, PLA Calanga 2010.

The use and provision of indigenous medicine is also influenced by intergenerational relationships that shape the therapeutic landscape depending on whether one is an adult or child. For example, children are only sent to the health care services by their parents. It is parents who judge the appropriate health service and therapy following their worldview, type of sickness, affinity or convenience. The knowledge, power and skills to manoeuvre indigenous health knowledge is also held by the elders who guide and orient the socialisation process and identity formation of the young. The elders also control the knowledge of indigenous medicine therapies and the relationship with the ancestors. In some occasions this power is used to reinforce the personhood described in chapter V.

There are times in which the relatives or the *therapy management group* decides which therapy to take and have to reach a consensus about the health care service to choose. Rituals for the ancestors, for the family or for one of its members are, in many cases decided collectively. The efficacy is not located in the isolated sufferer but in the group (sufferer, kin and ancestors). The configuration and ties of the networks play a significant role in deciding about the kind of therapy to provide and the health service to use. The social network is an important asset for patients in indigenous medicine, where individuals are relational and bodies composite thorough social relations, and as such, relatedness is one of the most important social capitals in health and therapy choice.

The influence of social relations on choice of therapy sometimes is compelling. For example, a Mozambican professor in one of Maputo’s private universities said to me, in a long conversation during my research:

“I don’t think indigenous medicine should be promoted (...) because it is magic/witchcraft. My father was *nyanga* and taught me to kill (using indigenous medicine). My Christian education only allows me to promote its plant component (...). But I accepted the *kutshiveleliwa*¹⁹⁸ for my son because I did not have a choice. If I had refused something would have happened to him, made by somebody, and people and family members would say that it was caused by me. I would be the obvious person to blame because I would have said no to the ritual (treatment) for the baby (...) they would say he planned to kill him to achieve the social success he has (...).”

In this account the professor’s ideologies and the narratives to sustain them are clear. However, the principles he defends in the narratives are at odds with what he really does. This is because the praxis and the relational nature of his personhood is not controlled and regulated by Christianity alone but by the principles of social harmony and compromise, which regulate both his and his son’s sociality and formation of identities. They also inform, regulate and control the representations of his survival strategies, health and therapeutic choice.

People do not choose the *tinyanga* simply because “(...) the traditional doctors or *curandeiros* play an important role in providing health care (...because) a large number of the population do not have access to the public health services, as a result of which they consult *curandeiros* as their only source of health care” (Monteiro 2011:30). Illness representation and knowledge, and social relations influence greatly the choice and delivery of therapy. According to statement from the Professor, I could argue that therapeutic choice is not always a choice but a survival strategy that compels people to use important techniques shaped by culture and history, in order to decide which therapy to use. The idea that conceives decision-making about therapy as choice therefore needs to be reframed.

¹⁹⁸ Indigenous medicine therapy generally performed on infants to prevent sickness such as *n’wamisiheni* and *wheti*.

6.2.1.3. Social Meanings

Another factor important in deciding which therapy to use is the social meanings given to the medical practices. For example, the available health practices and knowledge is treated differently by the local elites. The health field is stratified because the co-existing medical practices and knowledge are set apart in regard to social status and access to strategic resources, for example, in the area of planning and research. Indigenous medicine is given low status in official planning and as an area of research among academics. The state health planners who promote it consider it to be a subaltern form of knowledge that has to complement biomedical health provision. That is one of the reasons why they are interested on medicinal plants and phytotherapeutic agents. The academic establishment, with the rare exception of anthropological studies, conceals indigenous forms of knowledge. They also see it with biomedical gaze and paradigms and sometimes disregard it. For example a local influential scholar who teaches at Eduardo Mondlane University and works at the Ministry of Education said to me that “(...) the fact that more that 60% or 80% of Mozambicans rely on traditional medicine does not mean that we should promote it but that we should create more hospitals (sic)”. He discards and trivialises the corpus of indigenous medicine and the way it is functional in people’s experiences. Such attitudes and meanings are associated with colonial and postcolonial policies and practices seen in chapter IV, which promoted negative attitudes and hostile agendas towards indigenous medicine by the same people who (sometimes) also use it. As indigenous and biomedical health practices are treated differently by local discourses, and the former is in an underprivileged position, the *tinyanga* have no access to health resources and are deprived of development.

Modernity is symbolised and claimed through formal education and skills, biomedical fundamentalism, and evangelic ideologies, of breaking with ‘tradition’, discard spiritual agents and

embrace one God. These become symbols, meanings, signs and values through which the idea of modern culture is transmitted. Yet quite often the same people who have discourses against 'tradition' and claim this very modernity in fact use this tradition and visit the *tinyanga* and recognise their authority and power. They undergo indigenous therapies and take and give indigenous medicines for their children.

Contrary to the expectations of these historical ideologies and meanings the delivery and utilisation of indigenous medicine has been expanding and gaining new spaces and forms, as well competing with biomedicine. Biomedicine, although adapting to local health provision, aided by the ONHS and educational system, strives for expansion and for what Meneses (2000) called 'emancipation'.

Social meanings are also associated to the ways in which sicknesses are conceptualised vis-à-vis therapy. Sometimes people mix up diagnoses and therapies not because one expert or knowledge failed but because each therapy bears a particular structural meaning in relation to the illness. For example, many people in both Manhica and Maputo treat gonorrhoea both in hospital and at *tinyanga*. During or right after the treatment with pharmaceuticals they take indigenous medicines (*xilovekelo*) for a period superior to two months in order to eradicate the nucleus (*rhanga*) of the disease in the blood and clean the 'reproductive blood' (semen or vaginal secretions and reproductive system/ *ngati ya xinuna, ngati ya xisati, wununeni, ni mbeleko*). Hospital based therapy is never accepted as a unique solution. But indigenous medicine for this purpose (medicine x, and *xilovekelo*) may be chosen alone, especially in rural areas and by those who still do not accept treatment of the disease in the hospital. It is very difficult to discern the clear distinction that we may be tempted to make between indigenous and biomedical health services and the contradictions in which we get trapped when we analyse health delivery and 'choice'. In Mozambique's therapeutic landscape, illnesses are conceptualised with different forms of knowledge within local networks. In

these networks some are known to be treated better by indigenous medicine, others by biomedicine, and others by both concomitantly.

However, the 'choice' of therapy is not a rational process. Many people choose therapy in a specific health care service because they simply prefer to do so. They have no biases with any of the available health services, health providers or forms of knowledge. They look to health care services as a repertoire of options and go where they feel like. They go to "(...) *lomu mbilu yinibzelaka* (...)/ where my heart tells me to go to seek for therapy"¹⁹⁹.

6.2.1.4. Power Relations

The other factor that pulls or pushes people into choosing or accessing a specific therapy within the variety of 'healers' and institutions is the power in the shaping of the therapeutic landscape.

Before the elaboration of the traditional medicine policy and after the social break and economic collapse caused by the civil war, the State tried to moderate its policy concerning indigenous medicine and became more tolerant towards it. At that time the government did not design or declare any policy; it was mainly a change of attitude in relation to indigenous Medicine (Green 1995). It is in this period that the government led the creation of AMETRAMO in order to organise the *tinyanga* – or practitioners of indigenous medicine²⁰⁰ as they are called – at national level. But how did the State see this collaboration with indigenous medicine vis-à-vis the history of this Policy?

The specific objectives of the policy are to promote the development of indigenous medicine and its sustainable use in health care; encourage education and training, and credit the practitioners of traditional medicine (see pp 9-10). In the light of these objectives, the official discourse in the

¹⁹⁹ Informant from Maputo.

²⁰⁰ Praticantes de Medicina Tradicional – PMT's

meetings with the actors in public health and media, and in their diverse working plans reflects several perceptions, some of them stated in previous chapters. These perceptions reproduce forms of knowledge used to inform plans and deliver indigenous medicine that are imposed in the health field. Some patients learn about this medicine with these references and others ignore them in favour of the therapeutic landscapes presented in chapter V. In the next paragraphs I present some of these forms of power knowledge and strategies.

Firstly, it is erroneously assumed that the *tinyanga* are a homogenous community with similar medical practices. This form of reductionism perpetuates colonial classificatory approaches or, at worse, it demonstrates a lack of information about how and by whom indigenous medicine is provided. Conceiving them as practitioners of indigenous medicine ignores the diversity and specialisation within them. It could also imply that the *tinyanga* have no knowledge, epistemology, coherent medical practice or capacity to manoeuvre human bodies in health properly. Instead they just practice medicine by habit. They are reduced into an inferior position and denied authority, by pretending that the biomedical experts that control the formal health delivery have supremacy and should rule the patronage and tutelage in the health field.

Lack of information or, imprecise understanding of indigenous medicine is having a direct implication in policy implementation. How will the State implement a policy of traditional medicine if it has erroneous information about it? There is no adequate way of crediting *tinyanga* of an unknown community of practitioners or types. Taking into account that more than 60% of the population has only access to indigenous medicine, and that even a large percentage of the remaining 40% still use indigenous medicine, this factor is influencing the development of this practice and pushes therapeutic choice to 'informal' networks. If this dilemma persists, the policy will not be implemented properly and indigenous medicine will not be disseminated within a network so that people can make

informed choices. People will make choices driven by the ambiguities of the state. However, the informal network in which indigenous medicine has been operating has proven its own resilience and even vitality. Biomedical forms of domination are not passively accepted and in many contexts their exclusive utilisation is resisted. The continued authority and power of the *tinyanga* is above all due to the fact that it forms an independent corpus of knowledge. The *tinyanga* are also inciting the emergence of new forms of indigenous medicine that break local norms of practice and they are faced with no regulations to discipline their health delivery. In some cases some of the services that they offer such as increasing the size of genitals and promoting memory reinforce their stigmatization.

In Mozambique there is a perceived wisdom that the *tinyanga* have to be trained in the light of biomedical knowledge. The training plans on HIV/AIDS prevention designed for them by the Ministry of Health are a good example. An analysis made of these programmes reveals that they do not take into account the knowledge of indigenous medicine, as the following news about one of these trainings exemplifies:

“(...) Practitioners of traditional medicine were trained (...) on HIV/AIDS and sexual transmitted diseases. The training was oriented by the Department of Medicinal Plants and Traditional Medicine (DMPTM) of the Ministry of Health (...) how to use blades and needles was the target of this training”.²⁰¹

Kotanyi (2004) analysed a number of these programmes and concluded that they fail because they are based on a unilateral communication, not leaving space for interaction in order to facilitate mutual

²⁰¹ *Notícias*, 2005.03.01, page 6. The recently created Institute of Traditional Medicine presented in chapter IV also provides the same discourse.

learning of both parties involved, not using the knowledge of indigenous medicine and by indigenous medical practitioners but concentrating exclusively on explanations of biological transmission of diseases. The training quoted above (Noticias, 03/01/2005) is more concerned with surgical materials that are known as problematic in biomedicine for transmitting infectious diseases. The programmes are conceived from the top to the bottom since they do not value the development of beneficiary knowledge and they are treating the *tinyanga* as mere receivers. CIDE and IMP were reported in chapter IV with the same line of thinking.

Associated with biomedically oriented top-down training is the perception that the complementary relationship between indigenous medicine and biomedicine can be promoted without taking into account the distinctiveness between their knowledge, representations and practices. Apparently, it seems that the State is setting up connections between both medical traditions. However it is not, given that, in order to deal with indigenous medicine, the central planners at the Ministry of Health are, in effect, making it into a falsely integrated system. The State pretends that indigenous medicine can be transformed into biomedicine. The sponsored delivery of health information (for example on HIV/AIDS and malaria), and the consequent choice of adequate health care service and therapy is limited to biomedical circuits. Indigenous medicine health services and practices are effectively marginalised. Thus, to deal with these ailments one is forced to choose therapy (and information) at the biomedical health services²⁰². On the other hand the *tinyanga* compete with alternative success stories in which they claim efficacy of their treatments.

The biomedical establishment enforces the assimilation of its knowledge where education is intended to be key in the (re)production and dissemination of the 'authorised' medical practices. This

²⁰² The fall of HVI/AIDS and Malaria campaigns have raised debates arguing that the state should include indigenous institutions in the prevention and mitigation efforts.

ideological orientation makes sense of the imposition of a privileged discourse of those in control of the state mechanisms of health provision and reproduction. This can be questioned, for instance, taking into consideration that many Mozambicans who have no access to biomedicine, legitimise and accept the authority of indigenous medicine. The imposition of biomedical knowledge in the formal health delivery gives no 'authorised' choices to the majority of Mozambicans. They design and redesign the Contextual National Health Service that challenges the effectiveness of the Official National Health Service. They also create, (re)produce and represent alternative landscapes in which different forms of networks and solidarity take place. These coexist either in solidarity or in opposition with the State sponsored health ideology.

6.2.1.5. Efficacy

Efficacy is one of the main factors influencing the choice of therapy. The health services use chemical, symbolic-performative and persuasive efficacy to engender transformations from sickness to health. Their capacity to transform bodies influences the patient's decision making about where to seek therapy.

In plural landscapes, patients perceive that some health services provide better services and are more efficacious than others.

"We go there (to the *mazyoni*, *tinyangarume* and *vanyamusoro*) because we saw some people being treated successfully and getting better (...) x had a sickness and it was cured there so I also went there to solve mine because it was similar to the one healed there".²⁰³

In some cases efficacy and the 'choice' of therapy is unique to a certain service. The following passage illustrates the way a spirit medium can influence the choice of therapy:

²⁰³ PLA, Maluana 2010

“If ones health is jeopardised they can consult a *nyamusoro* and they can make us talk with our ancestors (...) they (the ancestors) usually give us strategies to solve our health problems. Many times we get better without going to the hospital (...) they tell us what to do”²⁰⁴

In this case the type of therapy (*kufemba*) is perceived to be efficacious in mediating with the extended body of relations with the ancestors who are known to be the source of illness management and locus of efficacy. As I presented in earlier paragraphs, the hospitals are also chosen easily when for example patients feel their illnesses requires an injection of liquids. Different knowledge and experience of personhood guides patient's decision making. Whether the bodies are experienced as biological, composed and fractioned or as relational informs the knowledge of who can heal successfully.

The *tinyanga* and biomedical doctors also use medicines as sources of their power to engender changes from illness to health. The array of medicines they know is important to improve their value and attracts patients. For example, some *tinyanga* do learn and prescribe painkillers and offer therapies to biomedical sickness such as malaria and AIDS. Doctors on the other hand have been accepting indigenous medicines and appropriating some of its products in their clinical practices. I witnessed doctors prescribing medicinal plants to their patients. The last physician doing so surprisingly prescribed plants that typically only a trained *nyanga* would know. She prescribed a plant called *muhlanhlovu* to a patient with a specific illness. This plant is generally known or used for this purpose by knowledgeable *vanyamusoro* because it belongs to a repertoire of medicines that are only transmitted among the *tinyanga* and their trainees. It is also deeply rooted in the *kuchayeliwa* (initiation of spirits in trance-possession) since it is used in the *govo* and *nhlambu* - medicines of the training in *wunyanga* (discussed in the previous chapter). As far as I understood from my work with

²⁰⁴ PLA Maluana 2009

this physician, she is not *nyanga*. She said to me that she has been learning indigenous medicines with two *tinyanga* because she believed that they offer 'better' and diversified health solutions. The doctors and the *tinyanga* use indigenous medicines and pharmaceuticals, respectively, in response to their availability in the local medical landscape, both of which are forms of the indigenisation of biomedical therapeutic practices and the biomedicalisation of indigenous therapies.

Efficacy is also associated with reputation. For example, families in Maputo cross districts and provinces to seek for 'good' diagnosis and/or medicines from distant *tinyanga*. These *tinyanga* are known by relatives or friends to have reputation to restore health or prevent illnesses. Sometimes their reputation is produced by the meanings of therapeutic talent associated to a specific region. For instance, the *tinyanga* from the districts of Magude and Guija, in the Northwest and North of Manhiça, respectively, are perceived to have talent in diagnosis. People in Maputo perceive that the *tinyanga* from Mambone, in Inhambane province, in the south of Mozambique are knowledgeable in some indigenous medicine techniques, to control people's *svxiviri* for instance. In these cases, the efficacy is built on the reputation of the *tinyanga* and regions which in turn may be constructed by kinship structures, therapeutic skills, cultural and ecological specificity, and history.

6.3. Conclusions

In this chapter I explored the relationship between health, therapeutic delivery and 'choice', and socio-cultural factors. I did not analyse all the factors that influence or determine the health decision making because that was not the objective of the chapter and some factors, such as geography and economics, are implicit.

I looked at the therapeutic landscapes in terms of health provision and 'choice' and described the repertoire of medical practices and health provision that feature in the local health field. Some are typically associated with biomedicine and others are associated with indigenous medicine, and Asian

medical traditions. People choose these medical practices and their 'choice' is influenced and determined by a variety of factors.

Different specialists are available in the context of those seeking them. In both rural and urban areas the *tinyanga* and biomedical practitioners typically respond to different forms of health problems using diversified therapeutic practices. The knowledge guiding the health practices is not necessarily antagonistic despite the fact that sometimes it is completely different. People attend, 'choose', alternate and mix up different therapies, from several worldviews. It is not just the epistemology underpinning a certain health care service that makes up the health field. Instead, the health field is constituted by patients' health seeking behaviour, factors influencing the therapeutic 'choice', and a repertoire of medical practices.

The distinctions that are normally made between traditional medicine (indigenous medicine), conventional medicine (biomedicine), and alternative medicine (Asian medical traditions) are not experienced as bounding or unified systems. Patients and health providers maneuver sickness in very creative ways, build up a contextual health service, and have a pluralized knowledge and abilities to survive in health and sickness. The notion of conventional and alternative medicine varies from one context to the other according to knowledge, expertise and abilities to navigate in the health field.

The idea that indigenous and biomedical forms conflict and that choosing indigenous medicine jeopardises public health only makes sense to its proponents. It is not appropriate to contrast these medical forms in terms of legitimacy, authority and usefulness for development. The perspectives in which health delivery and 'choice' are accessed and conceived by health planners and other local discourses, since experienced in a radically different ways in the context, are mistaken. They are

dramatically influenced by fallacious ideologies that make sense within biomedical epistemologies and establishment. As Bloom and Standing (2008) point out, public health planners fail to understand and use contemporary medical landscapes in order to address challenges associated with regulation and so fail to design health strategies to support local households in coping effectively with health issues.

The 'choice' and delivery of therapy is influenced by several intertwined factors that incite patients to choose a specific health service or therapy. These factors are, *inter alia*, the symbolic capital (Illness representation and knowledge, social relations); social meanings attached to health care services, power relations; and efficacy. They are related to the different dimensions of health provision and 'choice' in which they operate separately or together. There is a need to look at health delivery and 'choice' as a dynamic contextual located phenomenon centred on people and embedded in local social norms and knowledge, cultural ideologies, relations of power, socio-economic constraints, and ecology. In the health field, 'healers' from different medical traditions, patients and institutions position themselves to deliver and use health services. Looking at health delivery and 'choice' in this perspective my findings challenged the notion of therapeutic choice. I rather reframed it as a health decision-making strategy with techniques, shaped by culture and history, that people use in order to decide which therapy to use.

CHAPTER VII - POLITICAL ECONOMY OF HEALTH IN MOZAMBIQUE

7.0. Introduction

A concern with efficacy must include not only the way medical traditions produce, represent and negotiate efficacy to heal sickness and misfortune but also the way these productions are influenced and (re)shaped by political and cultural forces at national and international levels. These forces contest the meanings of health, sickness and healing. This chapter will consider how both political and geopolitical factors foster and inhibit local forms of production of medicine. I analyse economic and political dynamics and power relations that produce authorised and unauthorised medical practices and position their users. In relation to this, I have to answer how illness therapy and efficacy are contested by different stakeholders in modern Mozambique, and how social conditions and relations of power produce, reproduce, and legitimise certain representations of health and efficacy in the health field. I also analyse the interaction between local therapeutic landscapes and macro policies as well as the impact resulting from this relation. In this analysis I am interested in understanding how Mozambican actors respond to these policies.

The chapter is divided in two sections: Mozambique's public health field, and the geopolitics of efficacy to analyse the political economy of health in Mozambique.

7.1. Mozambique's Public Health Field

By *public health field* I mean the space in which individuals, cultural agencies, and social institutions use or are subject to different forms of power to legitimise and position their medical practices and the resources they use to deliver them²⁰⁵. In chapter III, I conceptualised the processes of social

²⁰⁵ I borrow the notion of field from Bourdieu (1990 [1980]; 1996) who uses it to refer to a specific space of social relations in which individuals and institutions are positioned and position themselves according to their agency. There are varieties of social fields that can be conceptualised according to the object in analysis (see chapter III).

legitimation and positioning following Pierre Bourdieu's notions of *symbolic capital* (*social, cultural and economic capital*), and *symbolic violence* used to expose the dynamics of power relations in social practices. He conceives the notion of capital as more broadly social, encompassing the economic, social, and cultural capitals that people use to compete with each other. Economic capital forms of material wealth, cultural capital refers to information (intellectual and artistic qualifications), and social capital he calls the existing or potential assets the individual or a group has according to its networks and relationships (Bourdieu 1990 [1980]). These three forms of capital become symbolic capital, which means that they have specific symbolic efficacy, when it is 'misrecognized in its arbitrary truth as capital and recognized as legitimate' (Bourdieu 1990a: 112, in Samuelsen & Steffen 2010). My reflections in this chapter follow this approach.

Medicine is a cultural practice embedded in social activities pursued by people in order to maintain or recover their health. It is part of but also constitutive of social practices. Questing for therapy is a health seeking behaviour that makes up the routines of the ill. But sickness and therapies, taking for instance the condition *ntima* and the therapy for social integration *mhamba* (see Chapter V), are social practices themselves because they reveal and model local social history, collective memory, and identities. The strategies people pursue to seek for and represent health, deliver therapy, and (re)produce their health practices are contested in terms of validity and legitimacy. This raises the questions: who should or should not heal and how? Why are some forms of medicine legitimised and others not? Responses to these questions lead to the processes through which the health repertoires compete with each other for recognition and are validated within the health field. The next discussions will respond to these questions.

In Mozambique's health field, the production and representation of illness, health, therapy and efficacy is dominated by different stakeholders who establish and contest the significance of medical

practices. This value is beyond the functionality, economics and availability incorrectly promoted by the systemic approaches and some discourses in Mozambique. Indigenous medicine has no formal role in the ONHS but has authority in the therapeutic landscapes. Biomedicine is funded but its economic apparatus does not give it value everywhere. Indigenous medicine co-exists with other well funded medical traditions in Maputo where it has authority and vitality. The value of medical practices in the health field derives from the relationships that different health practices establish among themselves interacting with the system of social differentiation. This interaction is historically located. The therapeutic landscapes, for instance, are structured and reflect the political, economic and cultural differentiation of people, agencies and institutions constructed in colonial, postcolonial and neoliberal time. As chapter IV showed, it is the colonial history of social discrimination and political exclusion that defined and prescribed that indigenous medicine was not authentic for formal health provision and that biomedicine was. Since the native population was not in control of the state, the *tinyanga* did not find 'partnerships' in the colonial regime to influence the recognition of their medical practice. After independence their networks and social relations with the elites shaped new positions in which connections were set up, the persecution stopped, and new forms of acceptance emerged. The reduction of state power over the control of the media and individual and economic liberties in the neoliberal era created new social spaces that are now occupied by different actors within therapeutic landscapes, reflecting this social system of organisation. Indigenous medicine and biomedicine created new therapeutic landscapes associated with the private sector and the power of the media and free marketing. The different 'healers' and patients are subject to and make use of the influences and dispositions within this health field to (re)produce and represent the power and authority of their medical practices.

Authority and power in the health field derives from variety of sources. These include social relations, types of knowledge, efficacy and reputation, cultural abilities and skills and agency as well as economic significance. In the last chapter we saw how these sources of value shaping for the recognition and legitimacy of healing traditions turn into commodities themselves. The institutions of indigenous medicine and biomedicine, kinship structures, individuals and their everyday medical knowledge and practices, and the techniques they use to influence the decision as to which therapy to deliver and choose, are socio-economic resources and commodities. On the one hand they are used to attract attention and acceptance due to their capacity to transform bodies and relations from illness to health (for example, people walk long distances to see a family *nyanga* who has the necessary reputation to deliver medicines for their children or a doctor who can inject liquids because these kinship and therapeutic strategies are providers of the acceptance of the medical practices), yet on the other hand, these sources of value are also commodities because they can be exchanged into social positions within the health field, and grant social, cultural, political and economic advantages for those who hold these social positions. The control of the state by biomedical health practices gives people with this knowledge and in these social positions a ready access to economic resources and spaces used to reproduce its apparatuses, such as formal schools and state funding. The control of indigenous knowledge, however, with its networks and techniques to reproduce this indigenous medical tradition, such as the concepts of personhood and the training schools (*mab'andla*), keeps indigenous medicine in privileged position in people's therapeutic decision making.

It is then worthwhile to assert that despite the fact that all medical traditions have the same purpose of healing people, and go about it in their own particular ways, they are of different social value in the different places and networks of Mozambique's health field, and are accepted in differentiated ways.

As Bourdieu (1996) would point out, the local forms and conditions of social production fix the authority of these health practises and of those who use them. For example, both indigenous medicine and biomedicine participate in the treatment of gonorrhoea / *xikandzamethi* but their efficacy is judged differently by local stakeholders. In this case the capacity of biomedical doctors is seen efficacious within biomedical discourses but the *tinyanga* and many of their patients conceive that the use of indigenous medicines is necessary for the restoration of the body and their efficacy is profoundly rooted in the local conceptions of the body. Thus the legitimacy and authority of medical practices is deeply associated with the positions and features of their users and providers within the health field. Taking into consideration that differentiation is intrinsic to the social phenomenon, in which the distribution of power is unbalanced, the validation of health and illness representation is made through the use of symbolic capital and violence by those who control the health apparatuses and institutions. In Mozambique this means, for example, the imposition of biomedical paradigms and discourses in the health field and an effort to create consensus about the domination. This includes the control of cultural symbols, knowledge and institutions where this very control is manoeuvred in order to produce, represent or impose their medical practices. These social elements that grant reputation, whether biomedical or indigenous, are subject to change and appropriation by its users. This is associated with the processes of social change such as the different metamorphosis of the institutions of indigenous medicine during the Nguni domination and neoliberal era, which brought about the *nyamusoro* and exogenous forms of indigenous medicine respectively. This can be exemplified by both the Nguni strategies to control local indigenous institutions (the *vahlonga*) and impose their paradigms and later by Mozambique's modern state endeavour to use the ONHS to control bodies and promote the epistemicide of indigenous health representations. In these processes medical practices undergo, for example, indigenisation and biomedicalisation in which elements that grant healing and reputation can be pursued or 'stolen' and claimed to reinforce

authority and power. Since medical practices reflect social positions within the health field, they are being pursued because of their value in healing, and the access to influence that this healing grants.

Social advantages and symbolic violence do not necessarily bring about attention, acceptance or reputation. For example, biomedicine in Mozambique struggles to validate its representation of illness, paradigms and efficacy in the majority of local networks. In places where they do provide health services, people do not always choose them but opt for their competitors offering indigenous medicine. In relation to this, it is worthwhile to refer to Meneses (2000) who pointed out that it is a paradox that the ideologies of valorisation and legitimisation of indigenous medicine are taking place in countries where their therapeutic landscapes need no promotion since they are considered legitimate and preferred by the majority of the population. In fact my research has shown that despite the power of biomedicine in the ONHS, people of all social strata, including biomedical practitioners, make use of indigenous medical strategies (in pursuing medicines for *wheti* (epilepsy) for example – chapter IV). Exogenous forms of indigenous medicine are also resisting the aggressive resistance of indigenous medical and biomedical practitioners, and managing to navigate in Mozambique's neoliberal therapeutic landscapes. This means that the health field is fractured and has different loci of power and consensus. It also reveals how the legitimacy of biomedicine, and indigenous medicine, is heterogeneously accepted and is not a definitive outcome. Underprivileged medical forms manage to make use of their everyday social practices and experience in relation to health to retain acceptance. Other forms of capital and conditions of social (re)production participate in the emergence of these forms of 'resistance' and resilience in the public health field. It can be argued that some medical practices have the power to manipulate or control others but this does not mean that they have any real authority because several other forms of capital are needed in order to exercise control with the consent of the patients in order for them to be legitimised and accepted.

Some of the most compelling forms of capital seen in early chapters are the training and apprenticeship institutions (*mab'andla*), the media, social networks, and the formal school system which produce practitioners, knowledge, meanings, power and authority for the different healing traditions. The relationship between these products and social actors in the health field is experienced heterogeneously since some people, communities or the majority of the population can accept, reject, tolerate, and resist them or play different and mixed roles in the encounter. The case of a biomedical doctor who prescribes indigenous medicines, defending their efficacy as learned from the *tinyanga* and asserting that they offer 'better' and diversified health solutions for people, shows a shift from the norm where these doctors are trained to learn from the biomedical apparatuses and perceive their knowledge to have a better reputation than that of other medical traditions. Another example is of the *tinyanga* who are in fact *vanyamusoro* but in meetings with formal biomedical institutions which are proponents of the 'plantization' of indigenous medicine they identify themselves as *ervanários* (*herbalists*). During my work with the former Department of Medicinal Plants and Traditional Medicine in policy development, I encountered a case of a politician well connected to the presidency, who I was aware was a *nyanga*, but he identified himself as an *ervanário*. The label '*Ervanário*' (*herbalist*) was used to represent the 'ideology' and symbols agreed by the biomedical establishment or, at least, to counteract the complicated perceptions associated with the *tinyanga*. Some of these perceptions are that the *tinyanga* are necessarily illiterate and that they have powers to read minds (do they?). Hence, it is better for *vanyamusoro* to use the label of '*ervanário*' to avoid difficulties in their negotiations in the field of power and social relations and meanings. In Maputo some *tinyanga* do not gain their acceptance exclusively through the 'traditional' capitals from their *mab'andla* or through the efficacy of their healing knowledge, but also thanks to their formal education which now adds value. The reputation of some *vanyamusoro* I worked with was not due to the efficacy of their healing alone but to the healing and educational capacity of their formal education

in different fields of knowledge (sciences, humanities and social sciences). Their cultural capital gave them some skills to provide interpretations and explanations of indigenous medicine – in the media and workshops for example - to those dispossessed from indigenous knowledge, such as those from the generation of people produced by the colonial assimilation and postcolonial Marxist policies. The efficacy of the ‘talks’ and ideas of these *vanyamusoro* feeds the empty spaces in the experience of people who in their daily lives have to deal with indigenous medical aetiologies – spiritual agents, indigenous sicknesses, agency of personhood, etc – but cannot understand the idioms of the *tinyanga*, who have not had this formal education, as generations of assimilation policies and colonial discrimination have disjointed patient’s cultural competence. The *tinyanga* communicative competence to explain works as a capital which grants reputation and authority. This does not mean, however, that there is a necessary correlation between cultural competence and the decisions taken by people to use certain type of therapy. In many occasions people do not understand a word of what the *tinyanga* and doctors say, even linguistically, but still use their services. This is because the production and representation of therapy is influenced by factors that reach beyond intelligibility. The cultural association between the therapist and patient is influenced by the many complex forces that produce and shape the health context, experience of suffering and efficacy. However, patients demand more explanations and understanding of some health problems. For example when people’s diagnosis requires complex biomedical surgery or a *mhamba*, within the context of indigenous medicine, they may consult different practitioners for better explanation.

An example of the creative experiences of the various actors in their relationships with the different elements of the field of power is that of the *tinyanga* when representing the paradigms and interests of biomedical establishment in the discourses about HIV programs. HIV & AIDS is politicised, and the discourses and positioning of the state and biomedical establishment use the paranoia imposed

by the sickness to validate its paradigms and foster the way those who argue against them lose reputation. Within this context, the *tinyanga* have learned to represent the symbols of biomedical modernity and in public and formal settings they tend to repeat biomedical explanations of the human body and of infectious diseases. However, in my field research, the same *tinyanga* acted differently in their daily practice and worked according to their own indigenous medicine knowledge²⁰⁶. They explained that when in biomedical setting they are repeating exactly what has been defined to them as right. Whether they believe it or accept it or not. They do this in order to navigate well in the state ideology and preserve their reputation in the health field. The biomedical knowledge is taken on board among the variety of other knowledge bases that they have and use as a form of capital. This is another way the health practices and their social positions are pursued for value and influence.

The representations above define social dispositions and the relationships that the different stakeholders establish among them as they respond to broader interests. They also show that the sources of legitimacy and monopoly of healing authority, derived from the relationship between the symbolic capital and the members of the health field in their pursuit for authority, are diverse, full of contradictions, and should not be predicted but verified in every health field.

7.2. Local and Global Efficacies

The local health fields examined here interact with the macro political landscapes in the production and representation of illness, therapy and efficacy, including those in international domains. Consequently, the analysis of the production and representation of medicine has to be extended into these domains. Some medical anthropologists who work in the area of political economy, contradict the bias and explanations of the well-documented dependency theories, and suggest that the

²⁰⁶ It is pertinent to question: what is the implication of these contradictions and power relations in the HIV & AIDS struggling?

analysis of relations of power between local and global health fields has to consider the mutual influence between stakeholders, focusing on power and defiance surrounding the representation of health, sickness and therapy; culture and historical specificity; as well as on micro and macro analysis (see Morsy 1996; Nichter & Lock 2002). In this section I will analyse the way in which indigenous medicine has responded to ways by which it has been represented in both local and global discourses and health practices. The conceptions and development of social policies, especially in the health sector, portray the nuances resulting from the political and economical arenas within governments and international institutions. This will commonly mirror the resulting power relations which may take different shapes depending on their interaction with the local landscapes and states.

The World Bank (WB) structural adjustment programs and policies in Mozambique are the starting point when discerning the influence of the global agendas on local therapeutic landscapes. The WB believed that the private sector, free trade, and open markets could promote economic growth and globalisation impacting on social development. This ideology had a large influence on local and national socio-cultural and economic structures that pushed the reconfiguration of local social networks and functioning of the health field. In Mozambique the economy turned from its centralised and communal organisational principles to liberal and individualised ones. Many people were impoverished and their social relations and networks changed dramatically. But other people and institutions maximised their profit, and attracted or accumulated capital.

The different health providers also had to protect and/or reshape their forms of authority and power in the new era. For example, state institutions invented new representations of indigenous medicine such as *etnobotânica* (ethnobotanical) and created agencies to capture and control indigenous medicine.

The available medical repertoires were expanded and new strategies created to deliver therapy within the therapeutic landscapes. The WB health packages forced the liberalisation of biomedical health services which produced the private health clinics and pharmacies to counteract the socialist centralised health provision. As chapter VI indicated, indigenous medicine also witnessed the penetration of new forms of practice and the commodification of its services. These therapeutic landscapes brought about new modes of solidarity, power relations and competition within the health field. The political liberalisation of the country also incited the restructuration of the efficacy of governance.

The democratisation process raised debates about traditional authority, including the *tinyanga*. It influenced the acceptance and promotion of civil society movements. For example, “in the 1990s, the Ministry of State Administration, with the support of the foreign donors, published papers, books and pamphlets which created the beginnings of a new understanding of what is called traditional authority in Mozambique” (Harrison 2002: 122). Civil society was seen as panacea for development and democratisation and development meant liberalisation in which the state had to give a voice to civil organisations and institutions. This neoliberal democracy is characterised by a state-and-society model in which “the local level (...) is no longer understood as necessarily backward, ethnic, or rural” (Ferguson 2006: 96). Here, more attention is paid to local forms of governance “through which the Africans meet their own needs, and may even press their interests against the state” (ibid).

The reasons why the state began to be concerned with traditional authority can be seen from a number of different perspectives. One of those is related to the premise that the state needs to recognise traditional authority because it enables it to enjoy legitimacy among the rural population so ensuring a better impact of the development programs at the local level. The state also needs to recognise traditional authority because it decentralises the political power in the country by using

them to administrate local territories (Harrison 2002; West 2005). In Mozambique traditional authority also “provides a pivotal conduit through which new forms of state administration in rural areas can realise themselves” (Harrison 2002: 122-123), including in indigenous health provision. The discourses in which traditional authority is promoted are seen as justified within these dimensions.

A second perspective can be that the state concerns with traditional authority are associated to its will to gain votes among the communities in order to ensure political support within the new democracy. If the state persecuted traditional authority, and if that traditional authority commands the respect of the population, the government would lose its votes to the opposition.²⁰⁷ From this perspective it can be concluded that the state is more concerned with its political support from the population rather than with the utilisation of traditional knowledge for the administration of development (Harrison 2002; West 2005). This can be well supported by looking at the state attitudes to traditional authorities. The traditional authority *Régulos* work in many state affairs at the local level, and walk for long distances to engage with their communities and state administration institutions but are still not rewarded. In the health field the state treats the *tinyanga* and their knowledge with a consistent bias. Its relationship with indigenous medicine is characterised by approaches that promote epistemicide and where the *tinyanga* are seen as subjects dispossessed from the capacity to think and develop their own agenda. The state is not interested in traditional knowledge such as local notions of personhood. Some health planners and other local elites, although using indigenous medicine as a health service, do not know how it works as a form of knowledge and a therapeutic technique²⁰⁸. The

²⁰⁷ In Chapter IV I discussed how RENAMO made use of the frustrations of population and traditional leaders during the civil war, capitalising on FRELIMO's mistakes.

²⁰⁸ João Fumane, intervention at the III *Jornadas de Saúde*.

state makes recourse to indigenous forms of authority and practices to control them and to legitimise its own political power.

One of the major debates on traditional authorities came from a Project organised by the Ministry of State Administration (MSA) and funded by international donors (See Lundin 1995a; Lundin, 1995b). This involved action research aimed “to produce recommendations for legislative and policy reform in relation to the issue of traditional authority” (West 2005:203). The work was based on the premise that the state needs to recognise traditional authorities since they enjoy legitimacy within rural communities and so recognising them would incite a more interactive and democratic relationship between the government and the rural people (Harrison 2002); key tools for development. Based on his ethnographic research in Mozambique, West (1998) asserts that the fact that the MSA project was not based on any field work²⁰⁹ led the researchers to the wrong idea that traditional authorities were only legitimised by the communities in which they exercise their influence. Traditional authorities, argues Harry West, are legitimised not only through kinship but also through different other spaces and networks intrinsic to the dynamism of the social and political systems. Graham Harrison states that the results of the MSA project was an understanding of traditional authorities in terms of systems of rule, while other factors that shape their constituency, existence and reproduction are ignored²¹⁰. Consequently, there is a need for observing historical and social factors that shape its constituents in space and time²¹¹. During my field work with the *tinyanga*, the *Régulos* and the

²⁰⁹ The MSA project consisted mainly of workshops for public discussions of previously compiled findings from earlier research about the issue of traditional authority (West 1998).

²¹⁰ “There is a problem with this framework. In the first place, consider the nomenclature of the analysis: traditional authority, chieftaincy...lineage social relations are here understood very much in terms of systems of rule” (Harrison, 2002, p122).

²¹¹ See West 1998; 2005, and Harrison 2002 for detailed and more criticism on this research.

Chefes de Terra in Maluana and Calanga, I understood that they are heterogeneous and embedded in a broader socio-cultural system based on lineage, kinship, authority, control of the knowledge and the relationship between the living and the ancestors. One more aspect that is not considered in the MSA work, which pays more attention to the traditional political leaders, is that the community of traditional authorities is stratified and heterogeneous with leaders, for instance *tinyanga*, of different types and categories such as *vanyamusoro*, *tinyangarume*, *vaprofeti*, etc (see Chapter V). The legitimacy of the *tinyanga* rests upon their reputation and authority in the control, representation and production of social, cultural and economic history, identities, health/illness, therapy and efficacy.

In the 1970s the World Health Organisation (WHO) started systematic debates, plans and strategies to promote indigenous forms of medicine in the world, and recommended that the state members take serious actions to implementing them (See WHO 2000: AFRI/RC/50; WHO 2009: WHA 62.13)²¹². The International Conference on Primary Health Care, organized in the former Soviet Union in 1978, produced what was to be known as the Alma Ata Declaration which recommends the regulation and integration of indigenous medicine in local national health system, so as to contribute to the objective of "health for everyone". Overwhelmed by the demand for therapy in many countries and the impotence of the biomedical healthcare services to deliver them to the majority of the population, especially in non industrialised countries, the WHO recognised the importance and role played by indigenous medicine. It was suggested that in order to deliver health services "for everybody" the governments should integrate indigenous medicine in their formal health systems (OMS 2001)²¹³. Indigenous medicine was seen at that time as a panacea for solving the problems arising from the weak coverage of biomedical services. Many countries have not gone far in following

²¹² At <http://www.who.int/en/>

²¹³ See the Declaration at the WHO webpage: http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

this recommendation to this day, however. The Alma Ata suggestions were more easily implemented in Asian countries where indigenous medicine was well promoted, but in African countries, local biomedical elites were not enthusiastic about the idea. In Mozambique the Marxist paradigm did not help. Small departments of traditional medicine were created but with all the ambiguities described in chapter IV. The Alma Ata declaration and others following WHO's recommendations were kept in the drawers of the Ministry of Health until the liberalisation of the country in the 1990s.

In response to the WHO's resolutions, in 2004 the government of Mozambique's designed the current policy on traditional medicine. The Policy aims to cover the entire health network and promote indigenous medicine as a complement to biomedicine. The paradigm in which this policy is being interpreted and implemented is, however, questionable, as has been discussed in previous chapters. The therapies of indigenous medicine are recognised in terms of plants, dispossessed from their symbols and meanings, where their efficacy is judged in terms of clinical models and according to chemical properties of plants used by the *tinyanga*. Some authors argue that African policies regarding traditional medicine and the argument to develop indigenous medicine delivery do not reflect the views of the population (Van de Geest 1997). Sjaak Van de Geest asserts that local "(...) communities may be less enthusiastic about the idea of integration than some of its advocates assume" because what they actually want are more hospitals and respect from doctors and nurses, etc. In her article she gives a secondary role and position to indigenous medical practices in relation to biomedicine. She calls the practitioners of indigenous medicine 'indigenous healers' whilst their biomedical counterpart she classifies as doctors, nurses etc. The study endeavours to analyse, homogenise and make speculations about indigenous medicine in Africa²¹⁴, yet her argument and the

²¹⁴ "I can only speculate about community perspective (about indigenous medicine (...)) in African countries (Ghana, Cameron, Mali and Zambia) (...)": Van de Geest, 1997, p 908.

unequal way in which this author treats the different health services and practitioners in the article is ethnocentric and reflects the power of anthropologists and their connivance in the reproduction of biomedicine. The fact that people want more hospitals does not mean that they are not interested in the promotion of indigenous medicine. In Mozambique, they clearly are interested and people participate in large marches and online TV and radio debates to support the cause of traditional medicine when the issue is put on table, especially on the African Day of Traditional Medicine (31st of August). If some people say that they would like to have a hospital in a particular place this does not divert the relevance of the development of indigenous medicine as a form of knowledge and health provision. It rather demonstrates the way people and communities categorise priorities, the type of attention that each medical practice needs in order to function, as well as demonstrating that indigenous medicine is locally emancipated. It does not mean that they will stop using indigenous medicine. People continue using indigenous medicine even when they do not wish to, since they are coerced by the social forms of obligation, their personhood and the reputation of the *tinyanga* in particular fields of health.

The policy of indigenous medicine in association with the WHO holistic definition of health, as a “state of complete physical, mental, spiritual and social well-being” represented and managed according to specific cultural standards, had some impact on the way some local biomedical researchers, for example in clinical psychology, related to indigenous medicine. The discourse started calling both biomedicine and indigenous medicine as forms of ethnomedicine and making respectful explanations about the diagnosis and therapies of mental illness within indigenous medicine (see Muthemba 2011). Yet the WHO and researchers described the physical, mental and spiritual, and what *individual* and *spiritual* entail, in a way that was at odds with the therapeutic landscapes and epistemologies of indigenous medicine described in chapter V.

National and local institutions and agencies did not assimilate the WB and WHO strategies without resilience and defiance. Indigenous medicine did not capitulate to biomedicine in Mozambique, instead it created strategies to produce and reproduce its community, authority and legitimacy due to the arrangements imposed by the macro policies. As a consequence of the liberal conjuncture, the *tinyanga* created and invented strategies and tactics to represent the efficacy of their health practices and maintain their reputation. For example, in the neoliberal free market described in chapter IV, the *tinyanga* reduced the period of training for *vanyamusoro* (*kuchayela*) in order to maximise profit, and the *mab'andla* reduced the hardness of the norms in the training process, and put many more *tinyanga* on the market than ever before. They also have been using tactics in order to deal with the state impositions of neoliberal biomedical health products from WHO and other international donors, such as repeating the contents of biomedical awareness campaigns in biomedical contexts but continuing using their epistemologies during their work. They also rejected the biomedical promotions of condoms and 'western' monogamy, and impose the validity of their knowledge within the indigenous therapeutic landscapes. This shows that the health field produced in the relationship between the global politics of health and efficacy and the local landscapes is not as simple as the current dependency theories pretend. Mozambicans, and their social institutions and agencies manipulate the direction of the health field in different ways and directions.

The neoliberal state incorporated indigenous medicine in its representations and governance and indigenous medical practices of communication with the ancestors (*kuphahla*) are performed in state activities and events. Representations of the State shaped by the so-called "traditional cultures"²¹⁵ is normal in postcolonial Africa and is documented in many ethnographic examples that show how indigenous socio-cultural practices such as rituals, discourse on witchcraft and spirit possession are

²¹⁵ Meaning indigenous African cultures.

used in ordinary activities and are also incorporated into the political sphere of the states or nationalist movements (Cf. Lan 1985; Ong 1988; Geffray 1990). Their production was preceded by the discourse on promotion and incorporation of 'traditional' authority and healing in local administration that emerged in response to the neoliberal political order. The state started representing and reproducing itself through indigenous knowledge or, as Achile Mbembe would put it, the postcolonial state is cultivating "African languages of power" that express African political models of power (Mbembe 2001).

When the president of Mozambique was inaugurated in 2005 and 2009, the official ceremony started with a ritual to announce to the ancestors that a new son of the land was assuming political power. Local leaders performed the *kuphahla* asking the ancestors to guide him and to be in harmony with the population in the development process. From this it can be seen that the repertoire of the state includes a form of spiritual supplication performed explicitly at the official level. In principle this represents the idea that, since people's activities and lives are interdependent with ancestors, if they are not involved in the process they can become angry and create instability.

Another case is when the governor of Maputo province put the first stone for the construction of the road between Maputo and Goba, in Maputo province. A ritual of announcement to the spiritual agents by the local traditional authority and elders was performed. The governor kneeled with them, and poured a wine libation and the traditional leader put snuff and informed the ancestors about the enterprise and requested them to be in harmony with the workers, and afterwards with the road users.

These cases demonstrate that the repertoire of neoliberal governmentality includes the knowledge typically associated with indigenous medicine. The administration of the state depends upon the

representation of this knowledge for the exercise of its administrative activities. Their performance is important since without it, people conceive that the enterprise will not succeed, and the spirits will create disturbance for the road users in the near future. People will also associate negative meanings and different kinds of impurities to the infrastructure, such as *ntima* and *xisila* or the disjunction of personhood described in chapter V. For example, in a situation where the ritual is not performed they will attribute every misfortune to that fact, sometimes diverting the attention from their own mistakes, such as leaving the cattle unattended in the road.

Indigenous representations of health and efficacy are idioms and constituents of the local and national therapeutic and administrative landscapes. Hence sickness, its prevention (or therapy), and efficacy is also social and political. It is beyond the WHO “evidence-based” reasoning in healthcare provision, constructed according to rankings of statistics that is also part of the national government repertoire of representations. It could be argued that the therapeutic landscapes of indigenous medicine are part of and form Mozambique’s political practice and representations. The appropriation and incorporation of this knowledge empowers the state and gives it a political voice among its population. This is very important in a country where the ‘western’ imposed modernity has failed to deliver its promises to incite development. To revert this, as an elder traditional authority (*Régulo*) in Manhica asserted, the state ‘seeks the help of the ancestors to rule the country’²¹⁶. These new forms of representation are also a product of the needs of Mozambique’s modern state to accommodate the new political paradigms and the local wishes and expectations.

It could be fallacious to consider the local therapeutic landscapes and the Mozambican state as purely passive receptors of international ideologies, since national and local institutions, agencies and interests when they encounter these models can, and frequently do, find them attractive and

²¹⁶ Obadias Chilaule, Calanga, PLA - 2010

useful. I have shown in previous sections that 'healers' of the different medical traditions and their patients use symbols of modernity, whether they are from indigenous medicine or biomedicine, to contest legitimacy and authority in local therapeutic landscapes. It cannot be assumed that the representation of the knowledge of traditional medicine is an external imposition. Instead, it should be seen as a will of the state to reproduce its cultural idiosyncrasies and to empower itself in the modern field of power. But it also positions and legitimises indigenous medical practices in the administrative field since their efficacy, authority, and reputation is always lined up in and for the development of infrastructures and the execution of multilevel state ceremonies.

7.3. Geopolitics of Efficacy

I use the notion of geopolitics to refer to the implications of economics and geography on political systems. These encompass the relations between state and non-state actors pursuing both individual and collective interests. *Geopolitics of efficacy* is meant here to be the field of political economy of health in which the representation of health/sickness and therapy delivery also reflects geographic and economic interests, as well as social positioning of societies, cultures and states.

The positioning and legitimacy of medical practices in Mozambique's health field is inextricably associated to past and current geopolitics of efficacy in the world. It is the history of 'western' colonialism, modernism and globalisation that imposed its economic interests and cultural standards including biomedicine and religion on the rest of the world. The power and contingency of the biomedical tradition of 'the west' meant that their idea of 'common sense' prevailed, ignoring indigenous practise. This was enforced by political occupation and persecutions (including killings) to conquer and legitimise the cultural, economic and political interests of the 'Western' countries. Their colonial models, including economics and imperialism were also enforced. In this, social change was seen in an evolutionary perspective in which all societies and human history have to follow the same

direction of those from the “western” cultures which assumed to have progressed further in terms of human development. That fallacy conceives of socio-cultural change as unidirectional and the “west” as the centre of departure for all societies to the change. The relationship between indigenous medicine and biomedicine, their representation, and the judgement of their efficacy was a product of this geopolitical space. The postcolonial configuration of the local geopolitics of efficacy was also influenced by the global geopolitical arena of the cold war, in which the socialist Soviet Union dominated the Mozambican revolutionary ideologies. In the socialist ideology of Marxism and Leninism, the efficacy of medicine is looked at from a material point of view as opposed to its spiritual manifestations.

The WHO recommendations and policies are not free from the interests, as well as strategic decision-making, of the global powers and multinationals and the power relations they have within the national contexts. The Alma Ata Declaration may be a demand to solve primary healthcare problems but the consideration and insistence in the promotion of indigenous medicine was a reflex of the geopolitics of efficacy of the Asian medical traditions. In the last 30 years the economic and political influence of Asian countries (mainly China and India) in the world geopolitical space increased dramatically. The positioning of China in the international and local political economy and health fields reshaped the representation and politics of efficacy of its indigenous medicine worldwide. For instance, in Mozambique until the early 1990s the economic interests of Mozambique were dominated by the United States of America (USA), the European Union and Japan but this geography of economic relations changed with the emergence of the so called emergent economies (Brazil, Russia, China and South Africa). In this shift, reinforced by the economic crisis that is affecting the old economies, and the collapse of the Soviet Union, China emerged and imposed itself as an alternative political and economic partner of Africa. According to Alden & Chichava (2012), this

was due to a number of things, including its competitive economic advantages, the less rigid economic conditions compared to those of the 'Western' countries, and to its revolutionary and historical ties with Mozambique. China's economy has grown 90 times since 1978; the highest economic growth in the world over the past 30 years. It is currently the second biggest world economy behind the USA and ahead of Japan, and its investments in the world are increasing dramatically. In 2008 it was the world's largest investor in the international market. Its trade with Mozambique rose from USD 48 millions in 2002 to USD 517 millions in 2009 (Chichava 2012). Chinese interests rank from cultural exchanges in education, infrastructures development and health. Its flows include migration, finances, Chinese indigenous medical practices, services and products (acupuncture, massage, medicines, etc). Thousands of Chinese people come into Mozambique every year. Mozambique receives loans from the Chinese government and banks.²¹⁷ Chinese companies are involved in every business, and its medical traditions are now a significant part of the therapeutic landscapes in Maputo.

The Chinese phenomenon represents a significant change in Mozambique's political economy of health since the social and political prestige and power of its economy and culture is reflected in local geopolitical space. They have been occupying positions of power within the health field and (re)produce their medical practices and resources across the country. For example, Mozambique's parliament approved the law that changes the regulation of the practice of private medicine.²¹⁸ This was carried out in order, among other things, to legislate for Asian, mainly Chinese and Indian, traditional medical practices, and to instate the government as their proponent. The argument was

²¹⁷ For example, china is financing the construction of the circular road (Estrada circular) that will circumscribe Maputo city, including the bridge to cross the Maputo bay.

²¹⁸ Lei da Alteração do exercício da medicina privada

that the previous law (Lei 26/91 de 31 de Dezembro), which was approved when the private sector was introduced in the country, only legislated on biomedicine and excluded other medical traditions. Therefore in order to broaden the space of collaboration between the private and public health provision, institutionalise the 'Order of Doctors'²¹⁹, and accommodate the use of alternative medicine (Asian) in Mozambique, there was a need to make changes in the ONHS. This meant that Asian medical traditions developed far more political status than indigenous medicine in the new geopolitical space. The ONHS was legally reframed to balance the power of these forms of medicine. Local associations and NGO's of *tinyanga* and the promotion of indigenous medicine were heard by the parliament. They condemned the fact that the state was favouring and investing in exogenous medical practices to the detriment of the local indigenous medicine used by the majority of the population. In that hearing, working for PROMETRA, I proposed that the new law should focus on indigenous medicine and exclude Asian medical traditions, which should be legislated once local indigenous medicine had been included. My argument was firstly based on the fact that this legislation was unfair and did not ensure that indigenous medicine had access to state planning. Secondly, the *tinyanga* with whom I discussed the issue before the parliament hearing found it outrageous being downgraded to a low status. Thirdly, the state was proposing an elitist legislation which was favouring a tiny minority of Asians and Europeans who practice 'alternative' forms of medicine in the country. This was betraying the interests and rights of the majority of Mozambicans and was giving unequal access and opportunities within the national health system and state affairs. Lastly, the shape of the law did not make any sense in terms of the way current therapeutic landscapes where delivering therapy, and in relation to the ways national pride and identity could be promoted. The government position was that the "alternative medicines" should remain in the law and

²¹⁹ Ordem dos medicos

be legislated for because their deregulation was creating a legal lacuna and its practice had high economic value. However they ignored the fact that the lack of legislation of indigenous medicine also creates a big social and legal gap, and its economic and social value is far more significant to local livelihoods and health development than that of the “*medicinas alternativas*”. The law, which was passed in 2009 following the debate, was also contradictory to the government’s policy of traditional medicine and to the fact that it had just created the IMT.²²⁰ It can only be understood if placed in the geopolitical space created by the relations between China and Mozambique. The “*medicinas alternativas*” existed from the 1990s and their practitioners were involved in the elaboration of the policy of traditional medicine and different events for the promotion of indigenous medicine with the MISAU²²¹ and indigenous medicine organisations, such as the celebration of the African day of traditional medicine. During my participation at these events I understood that indigenous medicine was prioritised, and sometimes favoured. I also noticed that the “*medicinas alternativas*” did not have Chinese practitioners in these meetings, despite the fact that the Chinese were delivering health services in Maputo²²². The power relations changed amid the several geopolitical factors that I have been narrating which reached their peak with the visit of the Chinese President Hu Jintao to Maputo in 2007. During his visit, he promised a number of new projects, which included a \$6 million agricultural technology centre and a national stadium (in Maputo) that were both inaugurated in 2011, and a further cancelation of \$52 million of Mozambique’s debt with China.

²²⁰ Institute of Traditional Medicine

²²¹ Ministry of Health

²²² Most of them do not speak Portuguese. This may be one of the reasons why they do not participate in the meetings.

The geopolitics of efficacy incited the creation of new meanings and power of 'alternative' Asian medicine. The economic interests and modern positioning of China has (re)structured the relationships of power in the health field. The efficacy and power of Asian medical practices and of those categorised under the title of 'alternative medicine', now represent the symbolic capital of its holders which occupies new positions and (re)produce themselves in Mozambique. Mozambique's weak geopolitical positions occluded the efficacy and authority of its own indigenous medicine.

7.4. Conclusions

In this chapter I have analysed the political and geopolitical factors that reproduce and legitimise medical practices. I looked at the economic and political dynamics and power relationships that participate in this phenomenon and conclude that the different medical traditions and practices, despite their intrinsic capabilities to health delivery and to engender efficacy are given different social value, acceptance and legitimacy. Their value is associated with the different and multidirectional power relationships that result from the ideological, social and economic forces and interests. The sources of power and authority that grant the reputation to the health practitioners and their medical practices are diversified, contextually contingent and are manipulated in a creative way.

I have also analysed the interaction between local therapeutic landscapes and macro policies and looked at how Mozambican patients and 'healers' from the different medical traditions respond to this interaction by inventing and reinventing different encounters to represent the efficacy of their health practices and provision. The wider political economy of health produces different relationships, and forms of solidarity and defiance between the different health providers as they respond to broader national and global health interests and agendas. The social dynamics resulting from these interactions are holistic and are demanded in governance. The therapeutic landscapes of indigenous

medicine serve as idioms of, and feature the Mozambican states political practice and representations.

The analysis of the geopolitical space has revealed that the influence of the 'western' economic, cultural and political flows which impact directly on the geopolitics of efficacy has lost part of its power to China. The new geopolitical space now reflects the economic interests and the power that China has in the world. It also reflects the lobby of those who benefit from this power since they use it to reinforce their influence. The representation of local medical practices and their efficacy casts the symbols and positions of their holders in this historical moment in which indigenous medicine was placed at a lower political position in comparison to Asian medical traditions. This reflects the interests, power and ideological assumptions that transmit the social differentiation of medical practices in the public health field.

CHAPTER VIII - CONCLUSIONS

8.0. Introduction

This dissertation was motivated by the misrepresentation of, and apparent lack of knowledge about, indigenous medicine in Mozambique. This consequently raised the need to reveal the epistemologies of health, illness and healing; rewrite the historiography; and develop the knowledge of and about this medicine. The dissertation analysed illness representation and political economy of health. My thesis was that indigenous medicine is a form of medical knowledge and practice that represents its illness, therapy and efficacy according to specific epistemological foundations, rooted in the local society and culture. However indigenous medicine was being misrepresented by discourses, agencies and practices that battle to control health resources, knowledge and power in Mozambique. Within this, biomedical health paradigms, bodies, and representations have been imposed onto an imagined Official National Health Service (ONHS) whilst people, on the other hand, represent, legitimise, and seek therapy simultaneously in different epistemologies and practices of medicine within the therapeutic landscape creating a Contextual National Health Service (CNHS). This political economy of health is contingent on historical, socio-economical, political and geopolitical productions and constructions of health and efficacy within Mozambique's public health field. On the basis of this examination I argued that research and health development needs to rewrite the historiography of indigenous medicine based on ethnographic sensitive material and linguistic competence. The construction and justification of this argument was made in seven chapters: introduction; theoretical and conceptual approaches; methodological considerations; representation of illness in Mozambique; therapeutic landscape: indigenous medicine; therapeutic landscape: health delivery and choice; and political economy of health in Mozambique.

In the first chapter I presented the study, including the background and research problematic issues that motivated the study. In chapter II, I reviewed the anthropological theoretical frameworks and approaches on illness representation, efficacy, 'medical systems', and political economy of health. Among the different perspectives on illness representation, I decided to frame this study with the integrative approach which looks at and conceives illness as an historical, biological, cultural and social phenomenon with an arbitrary or necessary relationship to the body or culture or a mix of both. I presented the models of efficacy theorised by anthropologists and stated the need to verify them in indigenous medicine since previous studies were not based on the analysis of indigenous medicine itself. I also discussed the concept of a 'medical system' since it is where the notions of health and sickness are defined, the representations and knowledge about health and illness are organised, and therapy is demanded. In this discussion I framed my research with the notion of therapeutic landscape. I used this notion to explain the material and symbolic health and healing knowledge, health practices and experiences of indigenous medicine in Mozambique, which were found to be constructed through and constructing social practices and processes. The notion of therapeutic landscape also aided me in explaining people's experience with health delivery and choice. Here I revealed the relationship between health, therapeutic delivery and 'choice' by exploring some factors that influence health, therapeutic delivery and the health decision-making strategies to use health opportunities within the therapeutic landscapes. In the chapter on the political economy of health I analysed the way through which Mozambicans contest the recognition, validity and legitimacy of their health and illness categories and efficacy.

From the discussions above I summarised the key theoretical questions of the dissertation, which are responded in the next section (conclusions), as follows:

- What are health, sickness and healing for those who use indigenous medicine? How can we inquire into illness and efficacy in a way that mediates with the way health services are delivered and contested in this context?
- How is the health delivery and choice of indigenous medicine made in relation to the therapeutic landscapes and the way in which it has been historically represented?
- How is illness and efficacy contested by different stakeholders in modern Mozambique, and how do social conditions and power relations produce, reproduce, and legitimise certain representations of health and efficacy in the health field?

I relied on participant observation, informal interviews, the documentation of life histories, desk review, and participatory learning for action, presented along with the research location and strategy in chapter III, in order to collect the data to respond to the research questions. With the aim of structuring the analysis and arguments that underpin the responses to the research questions, in chapter IV, I explored the social and historical foundations of the representation of health/illness in Mozambique; tracing the continuities and discontinuities of the colonial and postcolonial regimes in relation to the representation of indigenous medicine. In chapter V, I revealed and built knowledge on local therapeutic landscapes of indigenous medicine. In chapter VI I examined the therapeutic delivery and health decision making. In chapter VII I analysed the political economy of health in Mozambique. This structure allowed me to respond to my research questions and come to the following conclusions.

8.1. Conclusions

Chapter IV explored the social and historical foundations of the representation of health/illness and efficacy in Mozambique. The argument of the chapter was that the debates about indigenous

medicine in Mozambique were questionable because they have endured, *inter alia*, socio-historical, theoretical, epistemological, and methodological constraints. I have shown the different ways in which indigenous health has been represented by local stakeholders during the colonial period, after the independence, and in the neoliberal era. During both colonial and postcolonial periods there was a hostile treatment of indigenous medicine in which biomedical philosophical and methodological approaches to health and illness supported by colonial positivism and socialist scientific materialism were used to control the health field and persecute indigenous medicine. In the former, colonialism created a legal and administrative apparatus to manage a social discriminatory system that swept away indigenous health and healing from the state spaces. The latter changed the control of the means and modes of production but remained discriminatory and reinforced the stigmatisation and persecution of indigenous practices. Within this there were also agendas of the dominant academic knowledge that has been trying to invalidate local epistemologies. The two eras impacted negatively upon the representation of indigenous medicine: the uses of Portuguese language recorded colonial and postcolonial derogatory expressions which are employed to classify and stigmatise indigenous medicine, people became 'schizophrenic' because they 'lived' in two social worlds, one 'authorized' where indigenous healing is denigrated, and the other, in which they use indigenous medicine but pretend it to be non-existent, while it is in force in their social practices. However between the two eras there were some discontinuities in the representation of indigenous medicine because the revolutionary leaders, unlike their colonial counterparts, faced formal opposition from the *tinyanga* and their cultural identification with indigenous medicine and political need for legitimisation created a gap between ideology and practice that ended up in the recognition of indigenous healing. In the analysis of the neoliberal era I have shown the influence of the neoliberal capitalist model and 'western' democratisation on Mozambique's therapeutic landscapes. I accounted for the emergence of state institutions and civil society associations of indigenous medicine with new modernity of

health. In the deployment of this modernity, the state institutions, biologists, chemist, doctors and positivist social scientists captured, biomedicalised and parted indigenous medicine from the context of the practice of the *tinyanga*. The epistemological autonomy of indigenous medicine and the capacity of the *tinyanga* to think are denied. *Tinyanga* fashion the biomedical discourses but this is at odds with their practice and they struggle to navigate within the new administrative landscapes imposed by the neoliberal era. In this neoliberal era the stakeholders participating in the Mozambique's health field use the representation of belief and resistance, epistemicide, religious neo-colonialism, and biomedicalisation in order to deal with indigenous medicine. The representation of belief and resistance are discourses that accuse patients and the *tinyanga* of representing the absurd and of resisting biomedical health offers. The epistemicide encompasses the ways through which the stakeholders, through well-organised apparatus, endanger, transform and try to extinguish the epistemologies of indigenous medicine in the health field. Religious neo-colonialism refers to the combat and displacement of indigenous health practices through Pentecostalism in order to keep the hegemony of the Holy Spirit and power of Jesus Christ in the health field. Biomedicalisation conceives sickness in terms of bodily processes and condenses indigenous medicine to medicinal plants reducible into biochemical healing agents that can be directed to physical bodies suffering from universal biomedical sickness.

The prevalence of the persecution of indigenous medicine during colonialism and socialism, its misrepresentation and concealment of it as a form of knowledge, and the aggressive resistance from Pentecostalism in the neoliberal era, has to be critically questioned. I brought indigenous medicine into proper academic inquiry and have rewritten its historiography. An alternative way of inquiring into medicine is to use the philosophical and methodological paradigms of phenomenology and histories of social sciences because they value people's experience, put the patients at the centre of analysis

of health, and deconstruct the ideologies and power relations behind the health field. In chapter V, I used these approaches to examine how health, sickness and healing are experienced by those who use indigenous medicine. I conclude that health is an expression of harmony, stability and wellbeing, prevention and therapy of psychological, social and individual unbalances and shocks. This state is established in a continuous process of interaction and interconnection, and of interdependence and/or arbitrariness between the human body, culture, family and society. In this context the definition of illness has to be based on multidimensional and dynamic therapeutic subjects. It refers to anomalies, conditions or ailments in the internal and/or external corporeal, individual, family and/or socio-cultural relationships and history, which are reflected negatively in people's abilities and behaviours to conduct their social activities. This representation of medicine theorises on what health and illness is, particularly in Mozambique, but may also be tested in other medical cultures.

In chapter VI, I responded to the question about health provision and 'choice' looking at the features of the therapeutic landscape and the factors that incite patients to decide on using a specific health service or therapy. Mozambique's Contextual National Health Service is made up of different repertoires of medical practices and health provision which are typically associated with biomedicine, indigenous medicine, and Asian medical traditions. These medical traditions encompass different health providers who respond to different health problems and have epistemologically different forms of knowledge. People's decisions to use one or the other medical practice is influenced and/or determined by different forms of symbolic capital, historically located. Findings in this chapter challenged the notion of therapeutic choice since it is a health decision making strategy constrained by culture and history, with techniques, that people use in order to decide which therapy to use.

In chapter VII, in order to respond to issues of power relations in the representation of illness and efficacy by different stakeholders in modern Mozambique, and how social conditions and power

relations produce, reproduce, and legitimise health practices, based on my findings of previous chapters, I presented my reflections on the political economy of health. I concluded that medical traditions and practices have intrinsic capabilities to deliver health and to engender efficacy, but these capabilities must undergo social acceptance and legitimacy. These processes of acceptance and legitimacy are associated with the different and multidirectional power relations that result from symbolic power and ideological, social and economic forces and interests. These sources of power and authority of the health practitioners, the *tinyanga* in particular, and their medical practices are diversified and contextually contingent. I also analysed the interaction between local therapeutic landscapes and macro policies and concluded that Mozambicans respond to this interaction creatively in order to represent the efficacy of their health practices and provision. This interaction produces different relationships, and forms of solidarity and defiance between indigenous medicine and national and global health interests. These products, such as the health practices of indigenous medicine vis-à-vis the state, are holistic and currently feature Mozambique's social, cultural and political practices and representations.

While some aspects of the thesis have opened directions for future research developments, others could have been more developed. The unusual position I am in as both 'indigenous healer' (*nyamusoro*) and anthropologist is reflected in my strong justifications of the idiosyncrasy and internal structure produced within indigenous medicine. My arguments against the epistemological refusal of indigenous knowledge are written from this personal positionality and may seem overstated, as is the case in much engaged writing. I was unconsciously confronting the hegemony of biomedicine using its own terms, sometimes undermining my own critique of 'medical system', the dualism implicit in the concept of 'medical pluralism', and the very concept of therapeutic landscape that frames my research, which shows therapeutic fluidity as well as overlapping health practises. In my future

research I will focus on this fluidity, and on how different stakeholders engage, produce and are produced by material and symbolic processes and practices of the 'health fabric'. Some anthropological and health literature that was not used in this research will be of significant importance in this future research development.

The issues of power and authority discussed in the thesis explain the processes through which medical practices are accepted and legitimised. This opens up new landscapes to discuss issues associated with the politics of knowledge. How has my knowledge as an anthropologist impacted upon the representation of myself? What sort of landscapes are transformed and produced by *tinyanga* such as me? How this can be associated with the national and international (re)construction and legitimisation of health practises? These are some of the questions that I could develop in future research into the politics of knowledge and representation of medicine.

The therapeutic landscapes researched in this thesis are those within my own health practise, in the south of Mozambique. There is a need to undertake comparative studies in other parts of the country in order to improve our scientific understanding of the variety of health practises working alongside biomedicine.

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