Medicalized Healing in East Africa

The Separation of Medicine and Religion by Politics and Science

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ABSTRACT

For centuries, foreign notions of religion and medicine have divided African forms of healing into religious and medical aspects. This distinction developed into an institutional separation, which has proved problematic for African patients, who expect the previous unity of religious and medical aspects from their healers but are increasingly offered a medicalized, i.e. secular version of "traditional medicine" instead. There are different factors contributing to this discrepancy. For orthodox Muslims, Christian missionaries, and colonial doctors, while the use of herbs was acceptable, rituals controlling or addressing spirits mostly was not. Following the World Health Organization and the concept of "alternative medicine," substances and experts came to be regulated by the state or scientifically researched in accordance with "biomedical" notions of efficacy and safety. Thus, elements that could be classified as religious by both functionalist and non-functionalist theories of religion were increasingly excluded, first in external perceptions and research, and later in legislation and social reality.

1 INTRODUCTION

Healing services referring to African traditions are in great demand in sub-Saharan Africa, and national as well as international bodies are trying to regulate and promote the field. This poses the question of whether the demands of the local population and activities on a political level truly refer to the same thing. The evidence presented in this article suggests that what sick people and their relatives are mostly looking for from such services, which they do not find in government health facilities, is related to what could be called "religious" in most notions of the term. However, international and governmental health policies and scientific activities are dominated by tendencies to minimize or even exclude precisely such aspects. Concepts of religion, whose "use" here is clarified below, can be regarded as one of the central criteria in distinguishing between local and national or international views of what African traditions have to offer in treating illness.

The fact that internationally and locally organized religion, especially "enchanted Christianity" in Pentecostalism and charismatic Catholicism (Gifford 2015: 13–68; 107–124), has taken over much healing in Africa is well known and has been intensively researched. Whereas my previous studies on East Africa have concentrated on the influence of local religious practices and of Christian missions on the development of traditional forms of healing (Bruchhausen 2009), the present contribution will mainly consider the national and international political factors that have changed and even created "traditional medicine" as a mainly medical activity, instead of the previous practice in which the medical and religious aspects were fused. The focus will therefore be much more on the "medicalization" of healing than on its religious reformulation. In a global perspective, the focus on medicalization is also justified by the fact that, in both national and international politics, there were far more forces turning African healing into medicine than into religion. Thus, this article offers a fresh and substantiated look at the forces that are driving the religious aspects out of the practice of "traditional healers," seeking to go beyond the master narrative of an allegedly irresistible secularization in dealing with disease.

This difference between local hopes and practices involving the religious aspects on the one hand and the political or scientific interest in minimizing such aspects on the other constitutes the starting point for this study. The argument will be substantiated through limited reference to ethnographic

findings in order to illustrate the religious functions in this context and through an extended analysis of documents from different periods and organizations in order to show the various ways in which these functions have been excluded.

After an introduction to the terms, methods and materials used, I will summarize the present practice of consulting non-biomedical experts in the region of my ethnographic fieldwork in south-eastern Tanzania.

In the following, the difference between the local and the (inter)national will be demonstrated and explained in several ways, since monocausal views must be dismissed as outdated accounts of complex social processes. In my first explanation I will refer to comparable issues surrounding non-biomedical practices in Europe. For comparison and self-reflection, and to induce an awareness of interaction in the sense of an entangled history, current European attitudes towards such practices are briefly sketched and related to the situation in East Africa. A second way of explaining the difference between local demand and the political neglect of the religious dimension in healing is to provide a historical account of how European intrusions altered perceptions and practices during colonial rule. There are different pathways to account for the impact of foreign approaches on African healing, scientific research, international health policies, and territorial legislation respectively.

Before political independence, colonial administrators and academic researchers in both the natural and the social sciences increasingly noticed and also practiced a distinction between herbal medicine and spiritual practices. After Tanzania's independence in 1960, two different new approaches emerged to regulating the development of "traditional medicine": the policies of the World Health Organization (WHO) internationally, and Tanzanian national legislation on health professions and "traditional medicine". Thus, studying the influences on healing practices in East Africa must include colonial and current legislation, international and national health policies, scientific research and neoliberal commodification. Although these globalized and globalizing influences point towards the increasing functional differentiation of such distinct systems as medicine, law, science, education, politics, and religion (Luhmann 1999), these influences have encountered local resistance, often inspired by global movements, against the strict functional separation of healing and religion, like mystical Sufism in Islam and Pentecostalism and other charismatic movements within the mainstream Christian churches.

The final section before the conclusion returns to the present, to the recent Traditional and Alternative Medicines Act in Tanzania, and its impact on the religious aspects of healing.

2 CONCEPTS, METHODS AND DATA

Applying terms of European origin and highly contested meanings such as "religion" or "medicine" to African social phenomena is a major challenge that has long been debated in anthropology, theology, and missionary studies (Dilger et al. 2004). This is especially the case where the impact of complex European terms, in this case religion and medicine, constitutes the object of study, as in this article. The only meaningful solution to this epistemic problem seems to be an understanding informed by social constructivism: medicine and religion are what they are for the participants in the particular social construction of reality. This implies that, before the introduction of terms expressing the Muslim distinction between *tiba* and *dini* (two Swahili words of Arabic origin) or the European distinction between "medicine" and "religion," there might not have been anything like such differences for the inhabitants of the East African coast. However, it would excessively ethnocentric and arrogant to deny that Africans had what European observers called religion and medicine, as in the work of certain theological and scientific authors in the early colonial period (Bruchhausen/Roelcke 2000), before the debates emerged over concepts like "primitive religion" (Evans-Pritchard 1965) and "primitive medicine" (Ackerknecht 1942). The dilemma is obvious: subjecting African practices to European definitions could ultimately lead to one endorsing the neo-colonialist statement that they do not have such institutions, whereas using only the terms of the particular tradition would make translation and, especially, cooperation between the representatives of different societies or cultural traditions impossible. Therefore, the path to more shared, globally applicable definitions must be taken, even though it always risks introducing distinctions not yet known to the society in question. The debates between universalism and particularism, between liberalism and communitarianism, in political and moral philosophy revolve precisely around this dilemma.

One of the solutions to this dilemma is to use notions that carry as broad a meaning as possible in the case in question. Thus, in such contexts

"medicine" is not only defined by what medical doctors or the practice taught at university does, for which the term "biomedicine" has been introduced in anthropology (Bruchhausen 2011a)—it may also refer to any activity that deals explicitly or mainly with preventing, diagnosing, and treating illness. Although food, physical and mental exercises, and a clean environment might be even more important in preventing illness or recovering from it, they are not regarded as medical in this sense, but rather as related to "health". First of all, whether practices like those of East African ritual experts are called "medicine" or not depends on the broadness or narrowness of the definition of "medicine," but in the long run the definition itself may have effects on these practices. For mere reasons of convenience, rather than to emphasize any claim to supposedly proven efficacy, any foundation in biology or any static notion of tradition, the conventional, broadly established terms "medicine," "biomedicine," and "traditional medicine" and their adjectives will be used in this article. We must be aware, however, that "medicine" and today also "traditional medicine" are used by the respective proponents of these categories and the clients and politicians involved themselves, whereas "biomedicine" mostly remains a term used by external academic observers. What is meant by "traditional medicine" in the different discourses will remain one of the central questions. "Healing" is also occasionally used as a term indicating the broader functions of originally African activities.

Concerning the term "religion," taking a similar approach would mean that some of the classical debates between, for example, functionalist and non-functionalist theories (Stausberg 2009; Luhmann 1992: 9–71) or between definitions of religion as personal conviction, faith or experience and as social institution and doctrine (Taylor 2002), are left aside as far as possible. In some beliefs and practices in African healing, relating to the spirits is a subjective experience, as well as a social event and institution. Even if dealing with disease—the fundamental task of medical systems in functionalist definitions—were the primary concern or function of a practice, the tasks of assisting the patient to cope with contingency and of reassuring him or her of the existence of a meaningful, trustworthy world could fulfill the functionalist criteria for religion. It could, of course, be argued that any medical practice, including secular biomedicine, entails coping with contingency and reassures by means of rituals and symbols (such as white coats or stethoscopes), as several proponents of medical anthropology do indeed argue

(Helman 2007: 227). Yet these practices lack the open reference to a transcendent dimension which is a basic aspect of the concept of religion as applied in this article. Contacting invisible personal forces, praying for their assistance and making sacrifices to them, as established in most kinds of African healing (Magesa 1998: 188–198), would constitute religious activities in the understanding of most scholars of religion and probably most people in the world. The fact that early Christian missionaries and scholars called some African practices "magic," "witchcraft," "superstition," or "paganism," and thus denied them the status of religion, no longer prevents the present-day use of the term "religion:" indeed "African religion" is a well-established concept (Mbiti 1969). Nevertheless, such phenomena as sorcery, divination or spirit possession might still, by definition, be excluded from the term "religion" by some monotheistic theologians. In African theology (Magesa 1998: 13–35) and religious studies, however, a less dogmatic and narrow notion of what belongs to religion seems to be common. It is precisely this notion that will be applied here.

The article starts with a very condensed account of my findings from three years (2000–2003) spent studying the situation of medical pluralism in south-east Tanzania ethnographically, which I have described in detail previously (Bruchhausen 2006: 143–295). Interviews and participant observation in consultations and rituals were conducted in the premises of about ninety "traditional healers" identified for me by personal recommendation, the registration lists of the district office and the healers' association, the list of participating healers in the workshops of a mission hospital, and finally by inquiring in villages. The same methods were also followed in four government and three mission hospitals, as well as some health centers and dispensaries. Focus-group discussions in a hospital and on a healer's premises and a final survey of more than a hundred households validated the findings. The major research questions were how the experts and patients understood these services and where they saw their strengths and those of others, including possible reference to other experts. Ethnography forms a suitable starting point in attempts to understand all the forces that determine the religious and medical aspects of healing in East Africa. This descriptive approach, which aims at establishing the "emic" understanding, takes into account the fact that classification into either medical or religious traits is, from a certain perspective, a European categorical obsession rather than an identification of elements in an ontological sense (Krause, Alex/Parkin 2012). Looking at actual

practices provides an understanding of the local interests and foreign influences that make possible a deeper study of the dynamics that produce and determine the present situation. It allows us to ask why such close relationships between needs classified as religious and medical respectively were deeply changed by the encounter with the overwhelming secularizing modernity of the Global North.

Studying international and national impacts on African healing is different in kind. Doing so has involved the analysis of recent research literature and documents produced by political and administrative authorities, including the relevant public records in archives in Dar es Salaam, Oxford, Kew Gardens (London), and Berlin, as well as contemporary medical and scientific journals and international organizations, especially the WHO.

3 MEDICAL AND RELIGIOUS TRAITS OF HEALING IN CONTEMPORARY TANZANIA: ETHNOGRAPHIC FINDINGS

The social reality of health-related behavior, probably in most of sub-Saharan Africa, and certainly in south-east Tanzania, consists in an enormous variety of options. The majority of experts who can be consulted outside biomedicine are referred to as *waganga wa jadi* in Swahili. *Waganga* derives from a Bantu verb originally meaning "connecting," but here denoting the performance of special rituals for positive outcomes. The functions of the priest in offering sacrifices and relating to invisible personal powers, of the magician in divining and protecting against evil forces, and of the healer in caring for the sick were not separated in this concept, which is common to large parts of Bantu-speaking Africa and beyond. Today the term *waganga* on its own can be used for practitioners of both "traditional" and "modern" medicine, that is, healers on the one hand and doctors, nurses or other biomedical specialists on the other. *Waganga wa jadi* refers to the "traditional sector" only and is usually translated as "traditional healer," as *wa jadi* means literally "of yesterday" or "of the past" more generally.[1] In particular, as *waganga* is also used for biomedical practitioners, it has taken on the medical meaning of "healer." The abstract noun *uganga* still refers to the previous

1 A word like *desturi* would rather have the connotations of "tradition" or "custom."

broad range of functions. The Arabic term *tiba* is used for "medicine" in a narrow, rather European sense. *Tiba ya asili*, "medicine of the origin" or "of nature," is translated as "traditional medicine", while *tiba ya kisasa*, "medicine of today," or *tiba ya hospitali*, "hospital medicine," are used for "modern medicine," that is, "biomedicine".

Thus, if one demands to speak to a *mganga* [singular of *waganga*] *wa jadi*, one will be probably taken to somebody who practices a type of healing. Yet the variety of experts that fall under this name is broad. Some of them, all male, behave in several ways similar to a biomedical doctor, wearing a white coat, using a stethoscope, and selling pharmaceuticals, although their diagnostics do not follow the principles of a clinical examination and laboratory tests. If these *waganga* use herbal medicine, it tends to be already pulverized and issued in small bottles originally used for injections or large containers for tablets, a further reference to biomedicine. Such preparations can also be bought in small shops in towns, where long lists of diseases and other misfortunes, like problems in marriage, at school or in business, promise remedies against them.

However, the majority of the *waganga wa jadi* in southeast Tanzania are female spirit mediums, who, through an initial illness, have been called by their spirit(s) to serve, especially in healing. With this type of healer, the use of roots and herbs is embedded in contact with spirits: the spirit gives the diagnosis and shows which remedies are the correct ones. Often these healers become leaders in a kind of religious group in which variations of the traditional night-long drum dances are performed as major rituals intended to satisfy the spirit(s). These groups may exhibit different cultural or religious characteristics, some of which, like half-naked dress, the colors of red and black, drum rhythms, songs, and the names of spirits, belong to the African heritage. Under the influence of Islam, others resemble Sufi brotherhoods, with full white dress (*galabia* and head scarf), a flag of the prophet, a Koran, *dhikr* (rhythmic breathing) as incantation, songs without drumming, and sacrifices without alcohol. The reference to Islamic spirits supposedly renders the originally "pagan" practice lawful for Muslim healers, although for orthodox Muslims any dealing with spirits is *shirk*, religiously forbidden. In the mostly Christian regions, the function of such groups has been taken over by independent African churches in which the prophets are healers who also lead long rituals with dancing, trances and glossolalia.

Regardless of religious affiliation—whether originally African, Islamized or Christianized—these consultations and rituals obviously function both as religious services in the sense of contact with spiritual forces and as medical treatment by concentrating simultaneously on health problems. Yet what health problems do they address? At the end of my field research in southeast Tanzania, a questionnaire I had circulated, answered by a hundred households, clearly revealed local perceptions of the strengths and weaknesses of the different services. The results indicated an informal but factual division of labor between biomedicine and "traditional medicine," the former being more appropriate to the somatic aspect, especially through the impact of chemical substances and surgery, the latter to the more psychic aspect. Yet interestingly enough, scientific and political support for "traditional medicine" points in a quite different direction that favors the bioactive substances of medicinal herbs, not coping or healing through rituals. In order to explain this tendency, we must first look at non-biomedical practices of healing in a global and historical perspective.

4 "TRADITIONAL" AND "COMPLEMENTARY AND ALTERNATIVE" MEDICINE: AFRICA AND THE GLOBAL NORTH

4.1 Non-biomedical Healing in Africa and Europe

Equating African healing with European "folk medicine" or "naturopathy," as various discourses have done since the late nineteenth century, produced ambiguous results regarding the religious dimension. The obvious reason is that it repeats the variety of Europe's reactions and interpretations concerning its own healing traditions (Ernst 2000). Conceptions of the foreign mirror one's own preoccupations, in this case negotiating the relationship between religion and medicine in the Global North (Bruchhausen 2011b).

The broad current interest in "traditional medicine" in Africa would have been quite a surprise to Western observers in previous times. When Europeans' descriptions of African health care reached Europe during the colonial period, the general direction of medicine in Europe seemed to be inevitable, a matter of course, to many of the educated: medical science would increasingly govern peoples' health-related behavior, as older practices came to be

regarded as “medical superstitions” or existed only in new fringe areas such as naturopathy and spiritual healing, in opposition to the sort of medicine represented in the universities (Jütte 1996). Thus, African healing practices were categorized similarly, that is, as an irrational way of dealing with disease that would soon disappear, or, in some more sympathetic minds, as a possibly more natural and less materialistic way of healing (Bruchhausen/Roelcke 2000).

Yet in Africa as in Europe, the biomedical approach, despite its undeniable successes in many areas, did not conquer all areas of health care equally. The partitioning of the domain of biomedical practitioners and other forms of medical treatment and their experts, called “traditional” for countries outside Europe and “alternative” for Europe, seems to have converged in most parts of the world: the diagnosis, treatment, and prevention of severe infectious diseases, as well as major surgery, are mostly pursued in hospitals and pharmacies; patients with chronic or psychosomatic conditions quite often prefer to consult practitioners with a less scientific reputation.

Given the numbers of patients and the gravity of the health problems concerned, “traditional medicine” in African countries is a far more important issue than “complementary and alternative medicine” (CAM), as it tends to be called today in the industrialized nations (Moeti 2015). Due to its central role in African societies and to the longer tradition of ethnographic work on non-European situations, academic interest in the non-scientific aspects of healing developed in Africa much earlier and more widely than interest in the “folk healing” of Europe. But in asking how formal state control influences non-biomedical practices, industrialized societies, with their fully implemented administrative structures, may offer some fruitful entry points to the study of regulatory activities in a globalized world.

The term CAM itself—despite its reference to “medicine”—does not necessarily imply a preference for either secular notions of scientifically explainable effects or a utilization of religious elements such as reference to a "spiritual world". As governmental recognition of CAM is a concession to that variously large and heterogeneous part of the population that does not accept biomedical monopolism, the academic debate on CAM asks quite different questions (Sharma 1992). Is it rather a sign of post-modern “anything goes”, of disappointment at the unfulfilled promises of biomedicine, of the “re-enchantment” of a secularized world, of the new consumer sovereignty, or of the increasing market-place ideology of health care? All these factors,

of course, play their role to different degrees. Although the dimensions that refer to spiritual or psychological needs i.e. those discourses that address questions of ultimate causation and meaning of illness, will be at the center of this study the more economic and political factors underlying the popularity of CAM must also be considered. On the whole, these factors create an opportunity for interpretations of CAM in terms of both secular methods based on nature and religious activities. Under the umbrella term CAM, we find anatomy-based practices like osteopathy, the pharmaceutically sophisticated system of homeopathy, the "neo-pagan" rituals of Wicca, and the Catholic approaches to healing of the mediaeval nun Hildegard of Bingen. Dissatisfaction and liberalization can lead in quite opposite directions. On the part of the patients or consumers, there does not seem to be a strong need to distinguish or even separate the material and spiritual components of CAM practices, i.e. the scientifically proven biological effects of substances and procedures on the one hand and the mobilization of healing forces beyond the causality of the sciences.

A major aspect of a secular notion, however, is the growing demand for scientific research into CAM's effects that is being sponsored currently by pharmaceutical enterprises specialized in phytotherapy, foundations devoted to such therapies, and even public sick funds and private health insurance companies. Despite its much lower funding compared to research into other pharmaceuticals or into molecular and cell biology, such studies are a publicly visible part of medical research. The economic interest in traditional medicine and CAM is quite obvious and no longer concealed by reference to public service alone, as in earlier WHO documents and ethnographic studies. On the relevant WHO fact sheet for 2008, one of five "key facts" about "traditional medicine" is: "Herbal medicines are the most lucrative form of traditional medicine, generating billions of dollars in revenue" (WHO 2008). The explanation given later in the text is: "Herbal treatments are the most popular form of traditional medicine and are highly lucrative in the international marketplace. Annual revenues in Western Europe reached US$ 5 billion in 2003-2004. In China, sales of products totaled US$ 14 billion in 2005. Herbal medicine revenue in Brazil was US$ 160 million in 2007." Before the WHO turned its emphasis in this way from saving to making money from "traditional medicine," already in the 1990s in the United States the Eisenberg studies showed the high percentage of out-of-pocket expenditure flowing into so-called unconventional or alternative medicine (Eisenberg 1993,

1998). National and international bodies, like the European Union or the WHO, try to regulate the production, distribution, and application of herbal remedies. Yet so far, no African international organization, and only a single African state, Ghana, has joined the WHO's organization in this project, the International Regulatory Cooperation for Herbal Medicines (WHO 2010). There is no WHO collaboration center for traditional medicine in sub-Saharan Africa, the only one on the continent being in Khartoum. New national legislation for traditional medicine is growing in several African countries, and its effect on healing practices will be studied at the end of this article.

The overall effect of equating African healing with CAM in industrialized nations as implied by, for example, the WHO unit for Traditional and Complementary Medicine in Geneva is its construction and classification as herbal medicine. Even when "traditional" health-related practices that do not involve substances are studied in clinical trials, African practices are not included. Whereas acupuncture from the Chinese tradition, yoga from the Ayurveda, the mindfulness exercises of Buddhism, or even trances in shamanism and Caribbean cults are investigated for their impacts on health, making a scientific distinction between potentially useful plants and rituals not worth clinical study seems to be general when it comes to African healing. The religious or spiritual functions of African healing, such as the integration of experiences into an overall world view, the resulting motivations to serve others and accept misfortune, are not emphasized by its international and national supporters.

Having looked at contemporary situations and tendencies in the non-biomedical healing practices of Africa and Europe, we now need to see how they can be explained by reference to the various historical influences which used to favor a biomedical interpretation and the suppression of the religious aspects and functions.

4.2 The Impact of Colonialism on the Practice and Perception of African Healing

4.2.1 The Distinction between the Physical and the Spiritual or Religious Aspects of Healing

The way healing practices develop in our case—whether they are tied to or are removed from religion—is, of course, largely determined by the social

institutions that control the field. Both before and during early colonial rule, these institutions worked more closely to the traditions of the local population than under the later nation state. Control was exerted in condensed settlements among ethnic or social groups where functional differentiation was low, even in places where centralized kingdoms, colonial administrations or national governments exerted some political control over a larger territory. Before the colonial and later the independent state attempted to assume the regulation of healing—and in many instances long after this, even up until today—communities both large and small ruled such issues. They decided how ill-health had to be approached, what standards of health were acceptable or unacceptable, and which kinds of healing should be chosen. Religious features such as contacts with spirits, sacrifices, and reconciliation were indispensable aspects of such healing practices (Sempebwa 1983).

The modern state, both colonial and independent, did not feel responsible for African healing traditions in the same way as it did for biomedical services. This left traditional health expertise in a peculiar situation, with less control but also less recognition. But the colonial conquest, accompanied as it was by more Christian missions, ethnographic studies, and preventive as well as curative medical activities, had changed African healing by introducing fundamental European distinctions: science versus humanities, natural versus supernatural. Some practices, especially the use of herbs, were regarded as acceptable by Christian theology and by doctors, while others were denounced as mere "belief" or as "superstition." In doing so, the encounter with Europe established a marked difference between those aspects of African healing practices that are researched in socio-cultural studies like anthropology and those aspects that are evaluated by scientific investigation. This distinction affected politics and administration, criminal law, and the population concerned in both early and more recent settings. Thus, this difference must be considered central to all the discourses being examined here, even though—or perhaps because—it is certainly a product of colonial categorization.

This distinction between the physical and spiritual or religious aspects is also essential for a nuanced assessment of present-day claims in Tanzania that "traditional medicine" had been forbidden under colonial rule but has now been legalized. This prompts us to ask which parts and aspects had been opposed then but are being promoted today, a differentiation in which the separation between the physically effective and more religious constituents

of African healing has the central function. The common view of semi-official statements and published opinion is that it is only since 1968 that "traditional medicine" has been politically accepted in Tanzania, that it had been suppressed earlier, and that official recognition of the potential of "traditional medicine" is a necessary compensation for colonial injustice (Goergen et al. 2001: 4). This poses the question of how much of this generalizing statement is due to the African nationalist rhetoric that has dominated public discourses for several decades, and how much of it can be substantiated by evidence. What did colonial rule want to do, and what did it do to African ways of healing? Here the definition of what counts as "traditional medicine" becomes crucial.

If one takes the broad meaning of an anthropological approach—that is, attempts to arrive at an "emic" view referring to the notions and functions of the traditional experts in their own society—colonial rule has been certainly disastrous for the African population's ability to cope with all kinds of affliction, including ill-health. The role of these experts went far beyond private problems: they also judged certain general developments within their community to be dangerous and initiated counter-measures, such as the exclusion or reconciliation of allegedly harmful individuals ("witches") and even uprisings against the colonial rulers in cases of unbearable colonial burdens like new taxes or other orders. Motivating or even leading resistance by means of prophetic messages such as liberation from the evil of colonialism with the assistance of spiritual forces, especially in the Maji Maji war, brought these ritual experts into violent conflict with the colonial rulers and led to their persecution, including even their execution by hanging (Beez 2005). How and how deeply colonial agents and actions destroyed the traditional ways of preserving and restoring health have been demonstrated by Steven Feierman (1986: 206-210) with interesting examples showing that many health-related functions of the pre-colonial authorities among the Shambalaa-speaking people in northeast Tanganyika were forcibly brought to an end without relevant substitutes being made available.

If, however, one starts from the much narrower, biomedical notion of "traditional medicine" that most African politicians and officials also refer to today, the extent of the colonial-era destruction must necessarily be judged differently. In this perspective on the treatment and prevention of disease, one would have to distinguish—as both colonial and modern legislation does—therapeutic practices related to medicinal plants from the use of spirits

and the fighting of "witchcraft," as colonial discourses constructed practices of controlling evil (Langwick 2011: 46–57; Bruchhausen 2007). In this perspective, the colonial and post-colonial impacts on the spiritual-psychotherapeutic and herbalist aspects of the healers' activities were both quite different. When *waganga* were banned and persecuted, it was their function as political or religious authorities that was the issue of concern, especially their social, moral, and religious importance as experts in the management of affliction by detecting the guilty; that is, by "witch-finding," which was forbidden by the Witchcraft Ordinance of 1928, still in force today (Mesaki 2009, Tanzania 1998). Yet how did the Witchcraft Ordinance affect traditional healing? Was it meant to suppress all "supernatural" activities indiscriminately, or was it applied to troubles only?

At least in southeast Tanganyika, the British administration tried to apply the Witchcraft Ordinance in accordance with local public opinion. Initially, it did not feel that punishing witch-finders was absolutely necessary in order to prevent the exploitation of what they regarded as a credulous population. Some years later, in the 1930s, and contrary to the wording of the Witchcraft Ordinance (Cole/Denison 1964: 254–255), the Provincial Commissioners were inclined to distinguish between "benevolent witchcraft" or the "benevolent removal of witchcraft" or *"uganga"* on the one hand and *"uchawi"* as "black art" on the other (Guise Williams 1933; Kitching 1937). In 1933 an Assistant District Officer in Liwale requested that therapeutically acting "witch doctors" should not be imprisoned, even if a lethal outcome could be attributed to their practice, as long as they did not cause any social trouble (Beck 1970: 140). Some years later, even the Colonial Office in London raised the necessity of distinguishing between allegedly benevolent and destructive "witchcraft" (Keith 1938: 2). This attitude seems to have become the prevailing British policy in the south of Tanganyika, as can be seen in the recently published autobiography of a former district officer in Lindi and Masasi in the late 1950s. He notes major differences between the wording of the ordinance and the local administrative practice of its application:

"The official view of witchcraft was embodied in the Witchcraft Ordinance; I do not recollect whether it was the law itself or the practical interpretation thereof which was curiously ambiguous and liberal, but it was one or the other. White magic or *uganga*, in effect "traditional medicine" employing herbal remedies and psychology, tended to be beneficial and therapeutic even though accompanied by a great deal of mumbo-

jumbo and theatre, and was acceptable. *[Then he gives examples of its use by British officers, including the famous police investigations by Nguvumali.]* Witchcraft or *uchawi* however was another matter, and anyone who purported to practice it or who maliciously accused others of doing so, was liable to severe penalties in addition to almost certain banishment to a remote part of the country; such was the strength of superstition—or belief." (Barton 2004: 142)

Concerning the restricted European or biomedical notion of "medicine," according to which "medicine" comprises measures intended for the good of an individual only, the British administration was guided by the approbation of the local population and tolerated the practice of "employing herbal remedies and psychology." However, when it came to the much broader African concept of what ritual experts are responsible for, which includes accusing and fighting witches, local support for counter-magic was not recognized by the representatives of the colonial state. Therefore, it can be concluded that the general destruction of "traditional medicine" had obviously not been the intention of colonial officers who had to enforce the Witchcraft Ordinance in the south of Tanganyika: it was only directed against witch-finding, not against the treatment of the sick. Nevertheless, this ordinance has certainly destroyed much of what anthropologists would consider the previous cultural or social system related to health. It marked the transition from a pre-colonial system in which traditional authorities fought all those who were perceived as threatening the well-being of the community to a colonial system that made distinctions according to the functional systems of modern Western societies, here "law" and "medicine".

Given this separation of the "medical" aspect from the other previous functions of ritual experts, it could be argued that the effects of the Witchcraft Ordinances did not destroy "traditional medicine" but actually created it by medicalizing it. Rituals for treating the sick were acceptable to the administration, but rituals leading to accusations against others were not. Beyond the administration's acceptance of herbal medicine, the application of the Witchcraft Ordinances declared even rituals referring to the "supernatural" lawful as long as the purpose was restoring or preserving health—and doing so without causing social conflict. At least some of the religious functions of traditional healing, like placating sacrifices and incantations to angry ancestors or other spirits, although not previous practices like fighting evil human beings, could be allowed to survive in the eyes of the colonial rulers.

4.2.2 The Impact of Scientific Interest in the Tanzanian Context

Regarding those activities of *waganga wa jadi*, the "traditional healers," that the Tanzanian state seeks to promote and legalize today, mainly the application of herbal knowledge, there have never been any government attempts to prohibit them. This is even one area where the institutions imported from Europe showed more than just tolerance for African healing, one where herbal medicines were also actively promoted, reflecting a marked preference for the material over the spiritual aspects. During and after German colonial rule such knowledge was investigated with government support and regarded as potentially valuable (Bruchhausen/Roelcke 2000: 78–83). As far back as 1895, the director of health services in German East Africa, Dr Alexander Becker, had called on his widely dispersed medical officers to study native healing methods, including "devil dances," but mainly for them to send in specimens of medicinal plants (Becker 1896: 647–48). In 1969, in a similar circular to the Regional Medical Officers, the Tanzanian Chief Medical Officer in the Ministry of Health requested "research into indigenous methods of therapeutics" to be conducted (Institute of Traditional Medicine ca. 2002: 2), thus following the model of his first colonial predecessor, probably without realizing it. Only an initiative of the medical faculty of the national university five years later led to the permanent institutionalization of such research through the establishment of a Traditional Medicine Research Unit divided into the five sections of botany, chemistry, pharmacology, social anthropology, and clinical evaluation. As can be seen from the labels for these sections, the major tasks of this institution were the collection and scientific or medical investigation of medicinal plants and the study of other functions of "traditional healers". Whereas, after the unit's promotion to an institute in 1991, "Botany and Agronomy," "Pharmacology and Toxicology," and "Chemistry of Natural Products" became departments of their own, social anthropology remained something of an appendix. The scientific reason for this focus seemed obvious in the East African discourse, as one Kenyan pharmacist succinctly expressed it: "Traditional medicine, whether involving the supernatural or not, depends very much on the use of plants" (Tessema 1980: 48–54). The WHO African Regional Office in Congo Brazzaville is especially keen on reformulating African healing as herbal medicine within the WHO's Traditional Medicine Strategy.

Whereas national research and the promotion of "traditional medicine" both focus on herbal medicine, the ritual dimension did not remain completely unconsidered. Here, however, the main approach was to define this area as involving a cultural, and neither a medical nor a religious heritage. Thus, at the beginning of the 1980s the Tanzanian Ministry of Culture promoted the relevant drumming rituals in public by organizing competitions and studying songs and dances (Janzen 1992: 25). This was facilitated by the fact that the drum dances overlap to a certain degree, whether for pleasure, celebrations, or protection and healing. Not only do they have the general name of *ngoma* in common, which can be qualified by adding phrases like *ya majini* (for spirits) or *ya kutibu* (for healing) as religious or medical. The kind of music and dance and the musicians involved can also be regarded as largely similar and/or even as the same. The only elements specific to healing were the shape of the drums, the costumes, and other symbols, and of course the texts and the individual melodies and rhythms. Yet not only *ngoma*, but also *waganga* were in principle officially assigned to the government's cultural sector instead of to medicine or religion. Up until the recent legal change, their registration was with the District Cultural Officer (*Afisa utumaduni*), not the District Health Officer (*Afisa afya*), or else they were registered as religious congregations. Until 2002, too, it was the Cultural Office that issued permits to practice as a *mganga* after payment of the obligatory annual fee.

Summing up our findings on the influence of colonial as well as postcolonial administration and research, what today the WHO and national politicians call "traditional medicine"—mostly a kind of naturopathy—has not been administratively suppressed in East African countries, but in light of public demand it has been tolerated and even promoted. Yet, regarded as a whole, the precolonial sociocultural and religious function of healing has certainly been disrupted, especially by the activities of colonial states and Christian missions against those ritual experts who acted as political leaders, witch-finders or traditional priests. The difference between speaking of a whole social institution, such as the public protection of well-being, and looking at different kinds of healing practices is decisive in judging the destructive effects of the clash between African societies and the colonial state. The pre-colonial social system, where notions of the common good (including health and good relations with spirits) were widely shared between the general population and the authorities, had to give way to the rule of a

government with functional systems (including public health and medicine) whose experts tried to convince people of the validity of their relevant messages and institutions. Thus, this transition from a purely African, often ethnically restricted healing and health maintenance system, which was an inseparable part of a religiously constituted social order and world view, to the situation in the colonial and independent state characterized by massive European influence was not just a matter of a change in the ruling elite. Regulating healing experts and health was no longer just a local matter of clans, villages or ethnic groups—it acquired a geographically and socially much wider, though more focused dimension which had to deal with nationwide or even global functional systems like science, medicine, and law. The national and international agendas on health entered local choices and decision-making even in a field such as this that touched on questions of cultural and religious identity.

4.3 The Impact of International and National Health Policies

4.3.1 WHO Policies on Traditional Healers and Medicine: Using Healers or Integrating Indigenous Knowledge?

Whereas for the colonial and post-colonial state the main reason for tolerating African healing, including its religious components, had been political expediency—namely respecting the wishes of the population—the WHO had a different motivation that resulted in yet another concept of "traditional medicine." And, as in the case of the questionable colonial suppression of "traditional medicine," the usual narrative concerning the WHO's relationship with "traditional medicine" must also be questioned, or at least distinguished. This common view of the WHO's policy on "traditional medicine" seems to be that, since the Alma Ata Declaration of 1978 proclaiming "Health for all—by the Year 2000" (WHO and UNICEF 1978), "traditional medicine" should be integrated into national programs of primary health care (PHC). A closer reading of the declaration, however, tells a different story, as it speaks of the use of "traditional practitioners" within biomedically conceived programs only, not of the use of "traditional medicine" as a potential healing resource. While the first suggests complete subjection to

biomedicine, the second could entail religious functions such as the incantation of personal invisible forces as well.

The only section in the Declaration of Alma Ata that mentions the traditional sector argues that "traditional medical practitioners and birth attendants" should be recruited as "important allies" or even as "community health workers" through relevant "training" (WHO and UNICEF 1978: 63). It explicitly argues that the "high social standing" and "considerable local influence" of these persons—that is, the esteem they enjoy among the general public—could be used in PHC. This was in accordance with a previous resolution of the World Health Assembly (WHA) of 1976, which encouraged "the development of health teams trained to meet the health needs of populations, including health workers for primary health care, and taking into account, where appropriate, the manpower reserve constituted by those practicing traditional medicine" (WHA 1976). Related to this medical attempt to integrate healers are some studies in medical anthropology that tried to distinguish two types of healing (Foster/Anderson 1978: 53–65; Young 1983). One, the "internalizing" or "naturalistic" type that recognized the relevant pathological processes within the body and treated them accordingly—for example, with herbal medicines—was judged compatible with state medicine. The other, the "externalizing" or "personalistic" type, identified evil forces outside the individual as causing the illness and sought to counter them by means of magical objects, rituals and prayers. The practitioners of such forms of healing were to be left outside the governmental healthcare system, as their world view did not recommend them for co-operation. In anthropology, it could still be debated whether pure examples of each type exist at all, but the distinction as such was certainly influential—not only in health policies—and it contributed to the dichotomy between medicine and religion in academic, political, and public perceptions. As the anthropologist Robert Pool noted, this anthropological conceptualization was part of a major shift from religion to medicine: the same experts, rituals, and objects that had earlier been studied by the anthropology of religion were now often investigated by medical anthropologists (Dilger et al. 2004).

However, the attempt to use traditional practitioners as mainly preventive health-workers without government pay proved illusory. These plans on the part of the biomedical experts who dominated the Alma Ata Declaration mostly failed since communities were not ready to respect and pay healers for biomedically designed preventive medicine, and in any case the majority

of healers rejected being placed at the bottom of a hierarchical national healthcare system in place of their former independent authority and were thus saved from being incorporated into a completely medicalized setting. Such incorporation would have probably meant the end of any ritual activity, whereas avoiding close supervision by biomedical functionaries preserved spaces for religious functions.

At about the same time, politicians from countries with strong political concepts and institutions of "traditional medicine" that entered into their national identities, especially China and India, convinced the WHO to adopt a policy on "traditional medicine" itself. This policy was not related to health policies in general, nor to other health programs, and therefore the important spiritual or religious dimension could have been accepted. However, the opposite tendency became quite influential instead, that is, the definition of traditional medicine as the administration of substances. The first relevant document of the WHA on traditional medicine, dated 1978, focused on medicinal plants (WHA 31.33). In 1989, another resolution on "traditional medicine" elaborated research into medicinal plants and their regulation (WHA 1989). Two years later, the WHA demanded a "substantial increase in national and international funding and support […] to enable 'traditional medicine' to take its rightful place in health care," as well as "the use of scientifically proven, safe and effective traditional remedies to reduce national drug costs" (WHA 1991). Medicinal plants were at the heart of the strategy on "traditional medicine."

When, in the mid-1990s, the two strands, namely the use of traditional healers in a strongly preventive biomedical healthcare system and the use of "traditional medicine" as a curative resource, merged, the role of herbal medicine in programs was strengthened further. The revitalization of training schedules for "traditional practitioners," promoted by the WHO in the 1990s and still referring to their use as "primary health care workers" (WHO 1991), demonstrates a characteristic shift in the curriculum: those aspects that refer directly to traditional herbal medicine, such as the secure identification and hygienic storage of herbal remedies, receive attention first. Actions such as referral to hospital or supervising the construction and use of latrines—that is, the classic tasks of the village health-worker—come last in the list of subjects on training courses (WHO 1995: 64–65). In the WHO's "traditional medicine strategy 2002–2005" (WHO 2005), it was the aim of promoting

"traditional medicine" as a therapeutic resource for natural remedies, not of using its manpower in PHC, that received the most visible expression.

Thus, it can be said that the turn to the PHC policy since the 1970s certainly did not promote African healing in all its aspects, as it favored those elements that were regarded as compatible with science-based medicine and ignored those others that were regarded as depending on thinking attributed to the realm of religion. Therefore, medical development experts even warned that integration into the national healthcare system would lead to the "destruction of traditional medicine" (Diesfeld 1989: 90–91). If one wanted to save African healing from losing its overall importance for the population, the option of leaving "traditional medicine" as far as possible out of the administrative and judicial system and trusting local mechanisms of social control instead had much to commend it.

4.3.2 East African Legislation: Local and National Control of "Traditional Medicine"

Given the importance of local criteria for local practice, the way the colonial and later the independent state regulated African healing combined control at the local and governmental levels. In doing so, at least in theory, the interest of the population in services close to their own religious traditions could be made compatible with the obligation of the state to protect its citizens against harmful practices. Following the example of Western countries from medieval or early modern times, government responsibility for health was especially a matter of the legal status of health practitioners.[2] The relevant measures were introduced in the British mandated territory in 1937 with the Medical Practitioners and Dentist Ordinance Act, the first legal regulation of the health professions, modelled after European legislation. This Act forbade any medical practice without registration or license, but explicitly exempted such persons whose expertise in healing was acknowledged by their respective communities and whose healing activities were confined to their communities (Tanganyika Territory 1937: 409). Thus, the Act did not qualify the method of healing as natural or "supernatural," but took the assessment of the local community as the decisive criterion regarding the qualification of practitioners. In 1963, the legislation of the independent state did not alter

2 For the same aspect in the context of India see Rageth, this volume.

the section on local medicine and merely changed the reference to colonial institutions such as "the Crown," "Director of Medical Services," and "registers of health professionals" (Tanganyika 1963). Yet there is substantial reason to doubt whether this official "restriction on traditional healing," which confined it to a local practice, had been enforced in all the decades that followed up until new legislation was passed in 2002 (Harrington 1999: 226).

In 1976 the regional Africa office of the WHO in Brazzaville also defined a traditional healer as "a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background" (WHO 1978: 9). The reference to practices that do not rely on substances and physical intervention is remarkable but remained without consequence for WHO policies on Africa. The special legal arrangement for "a system of therapeutics according to local methods […] in a bona fide practice" was also set out in Tanzania's Pharmaceutical and Poisons Act of 1978 (Tanzania 1978, Part VI, 68 [1]). The following regulation, however, emphasized explicitly that it does not give permission to produce and/or distribute substances to persons outside the respective community, to sell or supply lethal quantities or preparations, or to add self-manufactured substances to any preparations of other systems of treatment. Thus, the goal was still that traditional remedies should only be accepted as local practices subject to the immediate judgement of local civil society.

Only after the launch of these WHO programs for "traditional medicine" (WHO 1987: 149–51) did this rather defensive legislative approach change slightly, culminating in Tanzania's Traditional and Alternative Medicines Act of 2002, which paved the way to the active promotion and regulation of "traditional medicine." The old rule that there has to be a relationship with a local public was partly maintained in as much as under this new law a "traditional health practitioner" is defined as "a person who is recognized by the community in which he lives as competent to provide health care" (Tanzania 2002: 3). This also allows such practitioners to practice religious ways of healing if the community regards this as adequate. However, the old restriction on practicing healing in one's own community alone is now omitted as long as the other regulations are respected. For like the so-called "alternative health practitioner" (with formal training in the respective therapeutic system), now the "traditional health practitioner" is also allowed (i.e. without

formally recognized training) to practice country-wide and in all groups, provided the appropriate official permission has been granted (Tanzania 2002: 21). Where there are strong ties to local religion—perhaps in the forms of ethnically bound spirits—shrines fixed to a grave or prayers in a local language, these forms are likely to disappear in cases of healing far from home. The old practice of healing outside one's own ethnic and religious group, which rapidly increased with urbanization and growing mobility, is now encouraged even by law.

The official governmental view, as expressed by the person responsible in the Ministry of Health, is that the new law of 2002 has taken the "traditional healer" and visits to him or her out of the "underground," from being "most […] an illegal thing" (Langwick 2011: 74). In contrast to this view "from above," the local population's experience—as a subaltern perspective—was somewhat different, as even before the new Act healers' activities and consultations had been quite public, especially for those who had paid their registration fee to the district office, but also for most others, far from the feeling of doing anything illegal. Especially in the case of drumming and dancing performed as a group in order to please certain spirits as part of healing rituals, there is no evidence that it was ever felt to be illegal.

In addition to legalizing the existing tendencies towards even more spatial mobility within traditional medicine, the legal and administrative regulation of "traditional medicine" also continues changes that had already been taking place for some decades.

The aspect of biomedicalization has been already dealt with. Professionalization is the final topic to be discussed here. As Feierman (1986: 205–6, 210–12) noted, the professionalization of "traditional medicine" strengthens the importance of such healers, who mainly treat strangers for material gain as a business, while at the same time reducing the role of those "care-givers" for "altruistic healing," who mostly treat relatives and neighbors free of charge as a kind of religious service and who used to carry out the greatest part of health care. In southeast Tanzania, the composition of the members of the healers' association, *CHAWATIATA* (*Chama cha Waganga wa Tiba Asilia Tanzania*), according to a list of 1053 names, does not at all reflect the actual care given (Nampyali, 16. 11. 2001).[3] Thus, the *wagariba*, the experts

3 Interview with B. M. Nampyali, Secretary of CHAWATIATA (Chama cha Waganga wa Tiba Asilia Tanzania).

in circumcision who themselves say that they do not heal and are not sought for healing, form a considerable proportion of the members' list, whereas female spirit mediums, who are more than 80% of those who are called *waganga wa jadi* or *waganga wa kienyeji* by the people, are found in the list less often.

Unregistered healers of this sort who have a rather spiritual focus will increasingly be excluded from any informal network of healers, as § 36 (1) of the Act says that registered traditional health practitioners must not "allow, associate or otherwise cause a person who is not registered as such to practice as traditional or alternative health practitioner" (apart from aides). Thereby, the once common referral of patients to those experts who are regarded as better or even exclusively suited to a specific problem, such as possession of the patient by a certain spirit, is no longer allowed if these healers are not registered. At this point, the national public interest that the democratically elected government claims to represent is at odds with a religious practice approved by local publics in the interests of the individuals concerned. The orderly professionalization of healing is not compatible with the motivation and practice of most spirit mediums who regard their call by a spirit, their initiation into rituals and secrets involving spirits, as well as their service to a community believing in these spirits, rather in religious terms.

Finally, it can be asked how the recent Tanzanian Traditional and Alternative Medicines Act of 2002 should be qualified—as accepting all aspects of healing, including the religious dimension, or as a further medicalization of it? Here the role of the market becomes central. As the Tanzanian Minister of Health, Anna Margareth Abdallah, mentioned in her 2002/2003 budget speech, the health sector reforms of the 1990s had among their goals "public/private mix reforms such as encouragement of private sector to complement public health services" (Abdallah 2002). There was no hint in the official texts at that time that "traditional medicine" should be one of these private services complementing the public sector, yet the new climate was certainly favorable to the idea of greater freedoms for traditional healers. Some expected that legal acknowledgement would give such healers greater independence from biomedicine, which could provide opportunities to increase the visibility of the religious dimension in healing. The actual development, however, seems to point in another direction, namely towards even greater similarity with biomedical practitioners. There is the desire that in East Africa traditional healers should be given professional biomedical privileges

that non-biomedical practitioners in other regions have already achieved, such as being financed by private health insurance and sometimes even by public sick funds, as in some European countries, or being able to certify the need for sick leave, as in South Africa. It would be the material rather than the symbolic power that would be strengthened by such achievements.

This new status of "traditional medicine" as a modern private practice rather than a traditional public service certainly also changes the healer's relationship with his or her patients and the spirit world. Moreover, it has an impact on the less professionalized ways of and experts in traditional healing who still practice without substantial financial gain and within the community of a quasi-religious cult group. At this point, the approach that treats "traditional healers" as a liberal profession might come into conflict with other, quite different arguments in favor of traditional healing. For, on the other side of the dialectics of "glocalization," those who advocate traditional healing as part of an African revival—as a constituent of a truly African identity—are usually not in favor of neoliberal globalization but emphasize rather the local, social and cultural integration of healing, not its autonomy from public administration. For such "traditionalists," the new professional opportunities for "traditional medicine" may further loosen their last ties with a former understanding of healing that saw illness often caused by invisible personal forces and treatment as negotiation with these forces.

Both these approaches to enhancing the "traditional" by giving it professional autonomy, as well as through its social (re-)integration, returns us to the question of the social practices separating those functions that are covered by the two functional systems of medicine and religion in more functionally differentiated societies. How should healing be approached legally—by applying the criterion of scientific and professional knowledge, or by referring to pure consumer choice? In fact, the public regulation and empowerment of traditional health practitioners according to the new Tanzanian Act does not go much beyond the colonial legislation, which already left the decisive role to local publics. This kind of social control leaves a space for versions of religious healing within "traditional medicine." Hospitals built by successful traditional healers for their clients,[4] where communal prayers, rituals with the healer or meditation in a holy place occupy the day for the temporary residents, rather resemble or even constitute the sorts of

4 An example for such a hospital is that in Mwera, southeast Tanzania.

congregations or monasteries that are known from old or new religions in several parts of the world. The spirit mediums can combine their roles as cult leaders and healers without much interference from the political administration. But, as a pure herbalist without any reference to a religious world view falls under the same Act as the keeper of a holy place or a spirit medium of the sort just mentioned, they are all officially labeled "medical." While earlier colonial and national legislation merely exempted them all from medical registration, the new legislation requires that they all be registered with the medical office.

5 CONCLUSION

Practices like the incantation of spirits, sacrifices to them or explaining illness with reference to their activities—practices that would be classified by most observers of today as "religious" in other contexts—constitute the probably most important part of what is consulted as "traditional medicine" in present-day Tanzania, but not of what, under this term, is regulated by national or international health authorities and investigated by scientific research. This equivocal use of the term led to the question of how this present relationship between the functions of medicine and religion was shaped by the various influences of encounters with people and powers from outside Africa. Nearly all these influences favored a separation of healing practices from their religious contexts and understanding. Doctors and scientists were mainly interested in bioactive substances, colonial and post-independence administrators were concerned to suppress possible social unrest arising from ritual practices, and Islamic and Christian experts tried to free healing from allegedly "pagan" ideas.

In this study, two common notions about the foreign treatment of "traditional medicine" have been questioned and disproved by means of further differentiation of what is meant by "traditional medicine": its alleged colonial suppression, and its supposed acknowledgment in the Declaration of Alma Ata on Primary Health Care of WHO and UNICEF. By distinguishing the social, mental, and religious functions from the physically effective means and practices, the commonalities between the attitudes of colonial administrations, Christian missions, the WHO, and independent governments are shown to be more marked than the differences: none of them

wholeheartedly embraced the ritual and symbolic side of "traditional medicine", but at best tolerated it, whereas they all expressed a much greater interest in the bioactive substances of herbal remedies.

It was the less orthodox versions of cosmopolitan religion, the Sufi or *tariqat* traditions of Islam and Pentecostal, Zionist, or charismatic Christianity, that opened up spaces for the adaptive survival of healing practices related to spirits and the countering of evil forces. Other healing experts organized their adapted rituals without obvious ties to a monotheistic religion. In either way, local wishes to keep the experience of ill health related to the experience of an invisible world of helpful and hostile beings find their satisfaction in new groups that have replaced the former ritual community of clans or settlements. Religious connotations of healing are now also present in many of the more commercialized and individualized encounters between healers and clients. But the very facts that all these experts are now registered with the district medical offices in accordance with national legislation on "traditional and alternative medicine," are being investigated by scientific researchers interested in herbal medicine and are being contacted by biomedical institutions for cooperation on certain health issues indicate and strengthen their overriding inclination towards medicine.

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