Articulate(d) bodies: Traditional medicine in a Tanzanian hospital

ABSTRACT
Hospital practitioners in East Africa see traditional and modern medicine interrupt and interfere with one another on hospital grounds everyday. In response, nurses and nurse’s aides have developed innovative ways of assembling diverse therapies and the knowledges, practices, desires, and medicines of which they consist. Through their care and coordination, nurses and nurse’s aides forge complex bodies within the therapeutic interruptions and interferences they face in their clinical work.

Nowhere in Tanzania is modern medicine seen as a sufficient resource to care for all health concerns and complaints. Not only patients but also biomedical practitioners and government bureaucrats recognize that biomedicine is only one element in a broader therapeutic ecology. In striving to meet health development goals, the Tanzanian ministry of health, with the support of the World Health Organization (WHO), the World Bank, and other members of the international community, has formally invested in the scientific development of traditional medicine since the 1970s and in the professionalization of traditional healers since the 1980s. The elaboration of traditional medicine through such laboratory investigations and bureaucratic management is filling out the category of knowledge and practice first evoked through colonial encounters and prohibitions. This genealogy begins to suggest the particularities of the pluralism shaping official postcolonial efforts to delineate and modernize a field of traditional medicine. To enable medical science to assess, evaluate, and deploy them, so-called traditional treatments and practitioners must be conceived of as resources for (and therefore distinct from) their biomedical counterparts. The (in)commensurabilities evoked in this vision facilitate the transformation of traditional medicines into pharmaceuticals and the reduction of healers to outreach workers referring clients to the clinic but not administering treatments themselves (Adams 2002; Janes 1999). This institutionally articulated medical pluralism and the forms of integration it promotes differ, however, from the more pragmatic relationship between modern and traditional medicine enacted in the clinic.

The clinic directs attention toward practice, highlighting the fundamentally interventionist nature of medical care. Clinical staff, as well as patients and kin, strive to attend to affliction, pain, debility, and misfortune; they strive to act. The urgencies and inadequacies of biomedicine in Africa shape the conditions under which interventions can be imagined and care carried out. Others have written of the ways that biomedicine crafts a space of emergency in which individual bare life marks the success of care.

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hierarchies that their separation enables.4 In arguing for dependence of traditional and modern medicine or the importance to institutionalized projects of integration, fewer anthropologists invest analytically in the intersection of traditional and modern medicine.

Although ideas of distinct medical systems remain important to institutionalized projects of integration, fewer and fewer anthropologists invest analytically in the independence of traditional and modern medicine or the hierarchies that their separation enables.4 In arguing for the changing nature of that which is called “traditional,” accounting for the sophisticated, shifting positioning of healers, and chronicling the emergence of new fields of knowledge, anthropologists have complicated many of the modernist agreements that have shaped studies of medical pluralism. Accounts of healers’ engagements with medical technologies (e.g., using syringes, reading patients' diagnostic tests, and combining their medicines with pharmaceuticals) and with biomedical concepts (e.g., addressing biomedical disease entities and arguing for the scientific validity of their medicines) challenge the self-evidence of boundaries between traditional and modern medicine. We have not, however, trained our attention as directly on the ways in which postcolonial biomedicine is being simultaneously refigured by the interruptions of traditional medicine.5 I am interested not only in the ways that healers innovate in the face of biomedicine’s interruptions (Langwick 2001) but also in the ways that biomedical practitioners innovate in the face of traditional medicine’s interruptions.

Hospital practitioners in Tanzania witness traditional and modern medicine interfering with one another daily on hospital grounds.6 The realities of affliction, discomfort, debility, and relief present themselves through the intersection of diverse forms of healing practice. Focusing on nurses and nurse’s aides in one district hospital in Tanzania, I describe some of the ways that biomedical and nonbiomedical therapies are coordinated in the service of treatment.7 As Annemarie Mol (2002) has demonstrated, biomedical practitioners strive to enact bodies that are coherent for a moment, long enough for therapeutic transformation or relief; or if one reflects on the root of the Kiswahili word kupona, to cure, then biomedical practitioners strive to enact bodies that cohere long enough to be cooled. Tanzanian medical worlds compel the coordination not only of the tests in the lab, the images from the X-ray room, and the intake history collected in the doctor’s office but also of the body (or bodies) of traditional medicine. Nurses and nurse’s aides are articulating new bodily assemblages; that is, they are joining together versions of bodies to allow for movement, for intervention into the complex life of pain, debility, and suffering in Tanzania. The very multiplicity of such bodies enables ways of acting within the therapeutic interruptions and interferences faced by clinical staff in their work. These newly articulated and articulate bodies have a temporal dimension, as do all objects in practice.8 They emerge in an effort to generate action, not to populate the world indefinitely. They cohere to direct attention as long as the care that they facilitate is considered useful. The institutionalized forms of integration imagined in health development programs differ epistemologically and ontologically from the more pragmatic relationship between traditional and modern remedies, healers, and knowledge in the clinic.

The work of the clinic seems to compel the cultivation of skills to discern afflictions or aspects of affliction that might be best treated by one form of therapy or another. To address the demands and the complaints that are made at the intersection of a variety of powerful ways of thinking about, articulating, and acting on the body, nurses and nurse’s aides in Tanzania cannot afford to think of traditional and modern medicine separately.9 In response to this reality, they are developing ways of coordinating diverse therapies and the knowledges, practices, images, desires, and medicines of which they consist. Nursing care comes to render bodies compatible with both traditional and modern treatments. To explore the complexity of healing in Tanzania, my account below focuses on (some of) the spaces in which therapies intersect with each other, forming therapeutic assemblages as health practitioners coordinate medicines, knowledge, well-being, and comfort.

**Hospital T**

The examples I present of different therapeutic trajectories interrupting, interfering, and transforming one another are derived from research I conducted in a district hospital in Tanzania, which I refer to from this point on as “Hospital T.” This hospital was built in the mid-1960s, after Tanganyikan independence, and assumed the responsibilities of an earlier Anglican mission hospital in the area. Historically, the state has underfunded this district hospital, even as it has tasked it with serving a particularly large catchment area in a relatively resource-poor region of the country. Although differences between clinical care in Hospital T and in other hospitals (whether in other parts of the country or the world) cannot be attributed solely to economic asymmetries, the practical challenges of running an understaffed, underfunded hospital with undertrained personnel are salient. In the context of my argument here, they are most important in situating the significance of the work of lower-level clinic staff in the therapeutic care available at Hospital T.

Since 1998, when I first became familiar with its staff and work, this hospital has supported one to three doctors.
Because it is located in a part of the country in which few elite, educated Tanzanians want to live, the government has found it difficult to keep a Tanzanian doctor in the hospital for more than a year. Since the mid-1980s, one or two of the physicians have been young German doctors working for the German development organization GTZ. With one notable exception, these doctors have tended to learn only rudimentary Kiswahili and have not learned any of the local languages. As a result, nurses and nurse’s aides field patients’ questions about medicines and address their anxieties about care. They are also the staff most frequently confronted with mediating traditional medicine and biomedicine in the clinic.

In 2003, the district nursing officer at Hospital T, burdened by the overwhelming task at hand, calculated the difference between the staff needed to meet the demands placed on the hospital and the staff that he was able to maintain. He concluded that from 2000 to 2002 the hospital was only staffed at 42 percent of the level that would have been required to adequately serve the demand. The percentage of trained nursing staff in 2000, 2001, and 2002 tended to be less than 50 percent of what the hospital needed. More specifically, the district nursing officer calculated that the hospital was operating with 52.4 percent of the needed public-health nurses and MCH aides, 43 percent of the needed registered nurses and nursing officers, and 36 percent of the needed “enrolled” nursing staff, which includes nurse-midwives. Hospital T has continued to function by hiring more lower-level (less well-trained) staff. In fact, the district nursing officer calculated that this district had 194 percent of the number of medical attendants it needed. Medical attendants can be hired who have no training at all. In the past, they handled jobs such as sweeping, cleaning, washing sheets, and making beds. In the current staffing crisis, however, medical attendants have come to dispense medicine, give blood transfusions, and tend to wounds. In light of their expanded responsibilities, most of the medical attendants in Hospital T have taken a one-year training course that teaches the principles of basic first aid and patient care.

Although these numbers speak to the specific conditions of Hospital T, they are in no way unique. In the past 15 to 20 years, clinical staff in Tanzania have struggled to provide quality biomedical care under increasingly austere conditions. In the mid-1980s, Tanzania began to implement an IMF structural adjustment program that required, as such programs have in many countries, the reduction of state expenditures on social services. Because a socialist minister of health remained in office until 1991, however, the full effect of the fiscal adjustments on health was delayed. Although private practices opened slowly through the 1980s, government clinics did not introduce fee-for-service or what are often called “cost-sharing” measures until the 1990s.

One Tanzanian NGO has referred to the cumulative effect and resulting conditions of these neoliberal reforms as “brutalization,” a term used to depict their impact on both nurses and patients. Under current conditions, nurses are unable to manage their clinics with the attention and care their professional commitments demand, and patients suffer these inadequacies when good intentions are a poor substitute for the treatments that they desire. Neoliberal reforms have had profound implications for hospitals and clinics in Tanzania, affecting the quality and sufficiency of staffing, the conditions of the clinic, and the availability of medicines (Lugalla 1995; Richey 2003). Faced with these harsh realities and the frustrations of not being able to offer ideal care, nurses in Hospital T seem to evoke traditional medicine in an effort to address the immediate needs of their patients.

I became intrigued by nurses’ engagement with traditional medicine after hearing healers’ periodic claims that nurses in Hospital T had referred certain patients to them. I began to formally investigate the issue by conducting in-depth interviews with all of the nursing staff in Hospital T. Between interviews, I would often remain in the wards and continue conversations with the nurses and nurse’s aides who were on duty, watching them work. Examining the mediation of traditional medicine within biomedicine drew me into the unofficial and private interactions that nurses and nurse’s aides have with patients and with each other. My formal interviews and informal conversations with nurses and nurse’s aides in Tanzania probed not only their encounters with traditional medicines but also the veiled references, euphemisms, and silences that enabled the presence of traditional medicine in the hospital. Although I conducted the majority of the fieldwork presented in this article in 2003, I have worked in the area of Tanzania in which Hospital T is located much longer. Between 1998 and 2000, I conducted research both in Hospital T and with traditional healers in the area in an effort to understand the therapeutic landscape. In fact, when I began hospital interviews in 2003 I was already known to some of the nursing staff by a diminutive form of the name of the healer with whom I work most closely.

My ongoing work with healers, as well as my commitment to and knowledge of this area, underlies the nursing staff’s willingness to confide in me and reveal the unofficial, sometimes clandestine, interactions that characterize traditional medicine in the hospital. These activities range from referring a patient to a traditional healer to facilitating the use of traditional medicines in a hospital ward. In addition, nurses and nurse’s aides described patterns of communication and innuendo. Their generosity and trust reveal a more fluid, flexible, and evolving picture of the relationship between modern and traditional medicine than has typically been portrayed in African hospitals. Here I not only discuss the existence of healers in the hospital and of their
medicine in the bodies of patients that arrive there but I also attempt to account for the intangible conditions through which biomedicine implicates traditional medicine and, in the process, hails new complex bodies.

For the nurses and nurse’s aides in Hospital T, the new sensitivities and practices of discernment through which they assemble the bodies of patients are not academic exercises. Neither are they in any simple sense driven by “interests” or “beliefs.” Rather, nurses are skeptical of healers. Ideological agendas shape the ways in which the nursing staff is implicated in the articulation of so-called traditional maladies, but nursing practice is itself not straightforwardly ideological. Stacy Leigh Pigg (1996) argues that articulations of one’s belief in or thoughts on traditional medicine are ways of positioning one’s self. The skepticism, even condescension, of clinical staff toward traditional medicine is shaped by their training, their position as “professionals,” and their position in the complicated class structures of postcolonial modernities (e.g., as people earning salaries in an area where many if not most are subsistence farmers). Medical staff’s claims about belief or statements about usefulness to a U.S. researcher, friend, or colleague are gestures within the deeply fraught landscape of modernity. Nurses and nurse’s aides craft themselves as modern subjects, as cosmopolitan, as legitimate embodiments of the state and exemplary forms of its citizenry. Despite their investment in boundaries between traditional and modern medicine, nursing staff come to discern more and less “dangerous” medicines, to assess “traditional maladies,” to mediate the encounters between traditional and modern medicines, and to articulate new complex objects that refuse to be reduced to either the biomedical or the traditional. Political, economic, and clinical conditions, as well as the diverse relationships that call on nurses in their everyday lives, compel them to coordinate the new complex objects of care that I describe below, that is, to generate more articulate bodies.

**Personal negotiations**

Twenty-three of the 26 nurses and aides I interviewed described using traditional medicine at least once in their lives. The chief nursing officer swore by an herbal treatment that he argued saved him from having to pull one of his teeth. Eighteen members of the nursing staff said that they had gone with or helped relatives and friends seeking out traditional treatments; eight either claimed that they had never taken or accompanied someone to a traditional treatment or they avoided the question. These differences in personal experience played a role in nurses’ and nurse’s aides’ own sensitivity to the use of traditional medicine in Hospital T. Almost all of them suggested that at least 50 percent of patients had used or were using traditional medicines. Only one nurse claimed that the use of traditional medicine was infrequent (*wachache tu*), and three suggested that it might be as high as 80 percent.

The personal experiences of nurses reveal some of the more complicated ways that traditional medicine exists in the hospital. After all, the nursing staff consists of people who are also mothers and fathers, spouses, relatives, and neighbors. One of the nurses in Hospital T lived across a small dirt road from a healer with whom I have worked for years. This healer and her kin would call on their neighbor with nursing experience (and vice versa) for assistance. When the healer’s granddaughter screamed late one night with labor pains, the nurse came running across the road to help. In addition, the healer regularly collected the leaves of a tree in the front of the nurse’s compound to make a medicine for a common eye ailment. Their individual experiences with healers and medicines shaped how clinical staff in Hospital T imagined the relationship between modern and traditional medicine.

Nurses born in the immediate area were more fluent in traditional medicines than nurses who were transplants from other parts of the country. The nurse who claimed to have seen the fewest instances of traditional medicine (despite working in the maternity ward, which has a history of some of the most controversial and tragic interactions between pharmaceutical and herbal treatments)—who was, in other words, the least sensitive to the use of traditional medicine in the hospital—was originally from Zambia. Explicating the relationship of hospital medicines to other forms of treatment was a way for nurses from the area to position themselves in the broader community and specify their own stakes in Makonde, Makua, or Yao subjectivities. Although religious affiliation appeared to influence the use of traditional medicines and their meanings, it seemed less significant than familiarity with local medicinal traditions in determining nurses’ sensitivities to the use of traditional medicines in the hospital. Nurses from the area, whether Christian or Muslim, tended to know healers as neighbors and not infrequently to be connected to them through extended kin networks. These connections shaped their knowledge about and sympathies for traditional medicine even more than religion or rank.

Through the use of traditional medicine, nurses and nurse’s aides often developed a personal philosophy about the kinds of traditional medicines that might be effective. Many nurses would only use *dawa za kukina*, protective medicines. Some claimed that their only use of traditional medicine was to wear a protective medical “bracelet” that they made themselves from ingredients bought at the market for their young children. Others did not “have faith” in medicine that was written or tied on to the body or buried in front of the door of a house; rather, they only believed in things that one drank, bathed in, or rubbed into the skin (*kuchanga*). Still others expressed concern about drinking medicines. They feared that the dosage might be too strong.
These women only used medicine that they could bathe in or rub on. Still others refused medicine that was rubbed on or tied on because, then, others would know that they were using traditional medicine. Some believed that traditional medicine was useful for particular sorts of afflictions but not others. Many claimed that traditional treatments for infertility or hernias were more efficacious than hospital treatments. Faith in herbal remedies for malaria or intestinal worms varied more widely. For still others, faith or belief in the efficacy of traditional medicines was irrelevant. Their use was represented as a product of family obligations and pressures. The uncertainty about traditional medicines, and the sorts of differences that were held as salient between traditional medicines, shaped the advice nurses gave to patients and the tolerance they had for particular kinds of treatments smuggled into the hospital.

Personal experience and professional experience bled together in nurses’ narratives about traditional medicine. As Mama Zenabu recounted her struggle to conceive and the various therapies she employed, she also described the “many, very many, too many” women admitted to Hospital T who used similar medicines. The impact of personal experience on professional work was, at times, as simple as the recognition and tolerance of traditional medicines in the clinic. Yet such stories also resonated with the more broadly generative capacities of affliction in Africa. In this area of Tanzania, as in other places across the continent, some are called to become healers through affliction. Their own healing depends on their submission to this calling. Their struggle for survival endows them with new relationships, new capacities, and new demands. When individual nurses grow more sensitive to certain forms of affliction and to a range of possible therapies because of their own experience, their expertise confounds any straightforward description of skill or knowledge. Through the excesses of their own engagements, these nurses highlight the friction between the forms of knowledge and expertise that inhere in profession and those that inhere in callings.

**Discerning affliction, mediating movement**

Whether nurses claim that any sort of traditional medicine is efficacious or beneficial, their work with patients who use these medicines requires that they engage with them. The medicinal use of plant, animal, and mineral substances affects the afflictions that are presented in Hospital T and, therefore, the routine practices of staff in the search for effective treatment. All of the nurses and nurse’s aides gave examples of traditional medicines that caused medical problems. One of the most common examples concerned herbal medicines that increased contractions during labor. Several nurses had witnessed women, their babies, or both die as a result of a ruptured uterus and massive hemorrhaging. The MCH clinic had made a concerted effort in previous years to discourage pregnant women from using herbal treatments. Nurses leading workshops to train traditional birth attendants (TBAs) still campaign strongly against them using any medicine for any reason. In addition to medical problems they attributed directly to the use of traditional medicines, hospital staff regularly complained that patients arrived in critical condition, sometimes “too late” to be cured, because they went to see a traditional healer before coming to the hospital (Langwick 2007).

Such public-health concerns have been addressed elsewhere, but what is more often left unexamined is the way traditional medicine comes to shape routine practices in the clinic. For example, many nurses articulated the importance of changing the treatment protocol for children with high malarial fevers who had been to see a traditional healer before coming to the hospital. Hospital personnel argued that the herbal medicines given to children afflicted by degedege, or convulsions, “cannot mix” with quinine. In 2003, national protocols made quinine the first response for malaria patients in critical condition. Although nurses widely agreed that “traditional medicine and quinine are like poison” (H22, also H11), they did not necessarily agree on what was to be done. They negotiated solutions on a case-by-case basis, which ranged from waiting for the traditional medicine to “finish its work” to easing this waiting with a glucose drip (H6), reducing the fever with paracetamol (H22), or stopping the convulsions with diazepam (H2).

The potentially fatal combination of quinine and herbal medicines to treat degedege—a common malady in which a devilish spirit plays with a person—often emerged in nurses’ narratives as an example of the consequences of failing to collect information on a patient’s use of traditional medicines. One of the most striking effects of traditional medicine on routine hospital practice is the time and effort made by nurses to extract medical histories from patients that include their recent use of traditional medicines. One of the most striking effects of traditional medicine on routine hospital practice is the time and effort made by nurses to extract medical histories from patients that include their recent use of traditional medicines. All nurses, even if to slightly varying degrees, were sensitive to the signs that a new patient admitted to the hospital had come from seeing a traditional healer. These indicators included the time reported between the onset of the malady and the patient’s arrival at the clinic, leaves visible inside the nose, bubbles coming from the mouth, traces of leaves on the body from medicinal baths, lines or smears of black or white substances on the body, the color and consistency of vomit or feces, and small marks on the body from razor-blade nicks. Nurses scrutinized patients’ bodies for signs that could be used to open conversations about broader treatment histories and for evidence that could be used to judge the truth or falsity of patients’ treatment narratives.

Whereas attending to the possibility of herbal drug reactions and collecting more inclusive therapeutic histories are fairly uncontroversial changes in clinical practice, the ways in which nurses and nurse’s aides mediate the use of
traditional medicine through their willingness to discharge patients from the hospital are both more subtle and more revealing. One nurse’s aide, Mama Zawadi, was explicit on this point. As we spoke about the different ways patients weave together modern and traditional medicines, I asked if she ever offered advice to those in the hospital. She replied,

Indeed, I can give a patient advice. Take, for example, a child who has been admitted here and after a month has failed to recover. The doctor changed the medicine this week, and he changed the medicine the week before. I will advise the caretaker to request a discharge in order to go home and take the child to a traditional healer. There are other children who have contracted maladies of swelling [magonjwa ya uvimbe]. This swelling is not something that is [known] here in the hospital, however, traditional healers, they can [address it]. Their medicines can help a great deal. [H26]15

Pharmaceuticals move from being a curative technology to being a diagnostic technology. In the process, Mama Zawadi comes to discern afflictions that are better treated by traditional healers. Mama Saidi echoed Mama Zawadi when she told me that sometimes caretakers “may request that their patient be discharged . . . [and at other times], my nursing colleagues can say to their patient, ‘Maybe if you go to a traditional healer you can get better.’” To leave the hospital before being cured, the patient or the patient’s kin must request what is officially called a “discharge without the doctor’s consent.” This bureaucratic technicality shrouds the nursing staff’s mediation of traditional treatments in the signature of a patient’s family member on the discharge form. Mama Tatu recounted another such incident:

One patient was in ward 2 [the men’s ward] in the first month. He had been treated many times before January. He was hurting. He threw up a lot. His feet hurt until he failed to walk, yet he was being treated. I advised him that having used a great deal of modern medicine, he should try traditional medicine. Therefore he decided to go to a traditional healer. I do not know where, but he has healed and he teaches over there in [a nearby primary school]. He had gotten completely desperate. He had been crying. After going there [to the traditional healer], he got medicine to close below [i.e., to rub on his feet]. He has been healed. [H14]16

When the clinical staff felt that their resources had been exhausted, the process of granting a discharge without the doctor’s consent provided a space to discuss the use of traditional medicine.

In the face of known chronic diseases such as HIV/AIDS, the inefficacy of treatments available through Hospital T may not have been as thoroughly tested. As Mama Aisha recounts,

There was one patient who had been admitted . . . he coughed a lot. He got thinner. He thought he had TB. When he came here he was admitted to ward number 4. When they tested him they discovered that he was HIV positive. Basi [here in the sense of “well, that was it”], when they saw this they said, “Now this patient will get this medicine then he will return home.” . . . He got the medicine for TB and they told him to return home, saying: “There is no need to drink this medicine in the hospital, it is better to return home. If you return home go to another healer. This is perhaps another illness, perhaps the mashetani [devilish spirits]. Therefore it is best to go to a traditional healer, they have treated mashetani.” [H18, similar to H12]

In this ad hoc, unofficial, and more or less clandestine practice of referring patients from the hospital to traditional healers, the strengths and weaknesses of various therapies were defined and redefined. The hospital was an active site of negotiation for both biomedical and nonbiomedical afflictions. The lack of antiretroviral drugs in Hospital T drove nurses to make bodies afflicted by HIV compatible with bodies afflicted by mashetani.

Most nurses, however, did not describe such explicit incidents. Rather, a more subtle conversation ensued. Patients would request a discharge, saying that they wanted to go to another hospital or that they had run out of money and their relatives could not afford to pay for them to stay in the ward any longer. Sometimes, nurses would attempt to foil these requests or to talk people out of removing their relative from the hospital. Some nurses claimed that they would respond to some requests by telling patients how dangerous using traditional medicine or mixing it with biomedicine was. At other times, nurses would confirm that the hospital had failed, that all medicines had been tried. Or they might reinforce the choice to see a traditional healer, by telling the family that they should not worry, that they could always bring the patient back to the hospital later if necessary. Much was unspoken in these conversations as the nursing staff refuged the boundary between compliance and noncompliance.

Not all advice comes from nurses themselves. Inside the hospital, patients and patients’ caretakers share concerns and experiences during the long hours they are preparing food and washing clothes. Talk emerges between kin and their sick relatives and among those who have come to care for their ill. There were animated and enthusiastic discussions in the bandas (thatched-roofed, open-walled shelters) set aside for kin to cook for their relatives and under the larger trees that provide shade to rest. Only a very few private wards existed in Hospital T. In the regular wards, patients’ beds were lined up in long rows about four feet apart. There, patients watched each other’s progress, commiserated, and advised. For instance, when on duty in ward 4, Mama Sofia witnessed an exchange between a
pregnant woman who had just been admitted to the hospital with signs of an impending miscarriage and a fellow patient in traction because of a broken leg. The woman in traction turned to her new neighbor, who had been prescribed strict bed rest, and told her that she would lose her pregnancy if she did not go to see a certain healer. Mama Sofia’s interest was piqued. She had struggled with her own pregnancy. By her own admission, she followed this woman’s case closely. The pregnant woman sought out the recommended healer and used her medicines. Her bleeding stopped, and she carried the pregnancy to term. She returned to the hospital having given birth to a healthy child. Mama Sofia did not hesitate to attribute this successful pregnancy to the traditional medicines the woman used, saying that all biomedicine had to offer the woman was “complete bed rest.” “Traditional medicine,” Mama Sofia concluded, “works fast.”

Traditional medicines shape both the ailments coming into the hospital and the routine procedures of hospital staff, but some nurses and nurse’s aides suggested that they are sensitive to distinctions between afflictions best treated by traditional medicine and those best treated by modern medicine. These cultivated forms of discernment, together with the failure of biomedical therapies to stimulate improvement or the diagnosis of a chronic or fatal disease, have led some nurses and nurse’s aides to selectively refer patients to traditional healers. This underground practice of referral reveals the hospital as an active site at which the attributes, potentials, and objects of traditional medicine are elaborated through their engagement with biomedicine and hospital staff.

In the examples I have given so far, the physical spaces of traditional and modern medicine remain distinct. This architecture of separation has been an important part of forging the contemporary category of traditional medicine (Langwick 2006, in press). Despite this work, however, traditional medicines and healers are also found in Hospital T.

**Hospital medicine**

Not everyone waited until leaving the clinic before seeking traditional treatments. Some used traditional medicines inside the clinic. As Mama Juma describes,

> Many can [use traditional medicine in the clinic]. During visiting hours, they leave, go to a traditional healer’s, and return. Others they can escape—going outside and returning [before their absence has been detected]. You cannot know [what patients are doing]. They tell you, “I am going to the entrance over there to buy bananas.” [She laughs.] They get [traditional medicine], such as those that you smear on, and then they return. They apply the medicines inside here, right here. [H20]

Patients or their “therapy management group” (Janzen 1978) secure medicines for use in the hospital.

In the process of describing the ways in which traditional medicine is negotiated inside biomedicine, I do not seek to romanticize traditional medicine but only to describe the landscape in which therapies are differentiated, ordered, and coordinated. Indeed, the use of herbal medicines in the clinic is not always a happy irony or a creative therapeutic convergence. At times, this more fluid form of “integration” has proven fatal. Mama Shida, a nurse’s aide, gave the following example:

> In this ward, there was one mama who brought her child. We treated this child. When we gave him another treatment he became completely unconscious. She did not understand [why this happened]. If we treated this child by using a drip . . . [and] after we had inserted it in him, she gave him traditional treatment in there, inside [the drip line]. I saw the signs of a person having come with his medicine. It happened at a time when they thought I did not see. They used water to extract the medicine [wakachujia]. This act of extraction was what I discovered. It was necessary to move closer to them. When I moved closer, I inquired [and] they showed me [what they had done]. [H25]

The mother of this child gave him an herbal medicine intravenously. The child died. Mama Shida attributes the child’s death to the mixing of traditional and modern medicine.17

Most often, traditional medicines used in the clinic were administered in secret. Hospital staff found only clues of their use. Mama Tatu refers to the use of traditional medicine in the clinic as “stealing away.”18 Other nurses confirm that some patients use medicines of traditional healers inside Hospital T. They put the medicine in a bottle, making it look like drinking water (H24), or a thermos, disguising it as tea (H20) or porridge (H6), or they hide it in the cupboard (H19). One of the nurses who works in the TB ward admitted to regularly finding medicine hidden in the beds.

Although nurses and nurse’s aides were concerned with overdoses and drug interactions, their critique of the use of traditional medicine in the hospital differentiates between kinds of treatment. Medicinal bundles wrapped in black cloth are found tied onto almost every child’s left wrist. In addition, most children who are admitted to Hospital T wear amulets protecting them from devilish spirits, such as those that cause convulsions. These medicines were never removed in Hospital T. Mama Zawadi also argued that no nurse would refuse the use of kombe in Hospital T. Kombe is a medicine made by writing in red saffron ink, usually on a white plate. The writing—an effect of spirits, ancestral shades, mashetani, or Mungu (God) working through a healer—is first read as a diagnosis of the patient’s...
The pharmaceutical medicine distributed by the hospital to conflicting patients or of witchcraft that makes it impossible for Allah, of a divine healing necessary to an undivided body manifestation of the "placebo effect." Others talk of God, of kombe as "psychological," and they interpret it as a local or other nonhumans. Some nurses speak of the effect of writings are verses from the Qu’ran, Arabic geomancy tales taken from popular Middle Eastern texts, or the embodiment of conversations with devils, ancestral shades, or other nonhumans. Some nurses speak of the effect of kombe as "psychological," and they interpret it as a local manifestation of the "placebo effect." Others talk of God, of Allah, of a divine healing necessary to an undivided body and soul. Still others talk of mashetani, devilish actors, afflicted patients or of witchcraft that makes it impossible for the pharmaceutical medicine distributed by the hospital to work.

Articulate(d) bodies

Bodies in Tanzanian hospitals are sites of assemblage. They are coordinated as nurses seek to elicit histories of patients’ use of traditional medicine during intakes, as standards of care are shaped by bodies full of traditional medicines, as healers on hospital grounds suggest traditional treatments for patients who are admitted, as afflictions resist biomedical regimes, and as nurses cultivate the skill to discern which patients might benefit most from alternative forms of therapy and which traditional medicines might be used in the clinic. In these instances, there is a momentary synthesis between versions of the body that emerge from different assessments, examinations, and treatments. To consider this point further I turn to one last example.

When the son of Mama Ramadhani, one of the nurses, fell suddenly and severely ill, she took him directly to Hospital T. As Mama Ramadhani sat in the ward next to her two-year-old child in critical condition, she began to wonder if he was affected by mateso, or witchcraft. She told me her story like this:

He was very sick. He had blood in his diarrhea. Because he was losing blood, he became anemic, and his body started to fill up, to swell. [While we were in the ward] one mama came there. She told me that mashetani had climbed on my child. She cried. I was told this. She cried. This mama, the traditional healer, did not say anything else. She left. The next morning, as we were sitting on the verandah [of the clinic], one baba [lit. father] came, and he told me that I should take the child to a traditional healer in a certain section of town. He explained to me where the healer was located. He argued that someone had played with this child [by pointing out that] we gave [the child] blood one day, and next day there was no blood and it is necessary to give him blood again. Indeed, [my son’s condition] was getting worse. The child had lost two [pint] bottles of blood. For this reason, my mother and I left. We carried the clothes of the child. We went to this baba’s [house] to divine [kupiga ramli]. He said that it was fine [to have brought the child’s clothes, rather than the child himself]. Later [however] it became necessary to bring my son. He was in the ward. Before the doctors passed through the ward on their rounds, we left with him. We took him to the healer. When we went there, the healer had to remove things. She removed things, meaning… she made small surface level cuts at the feet… you could see that there was something sticking out of [my son’s] tongue… after a little cut with the razor, she closed this section and then he breathed spitting out two things. There were ball bearings… [and] a mdudu, a louse… he had mateso, he did not fall, he did not do anything, but he had mateso of the foot, after this, after returning to the ward, we continued to improve, until we returned home, until today. [H12][20]

During her son’s illness, Mama Ramadhani continued to work as a nurse in the hospital. In the process of seeking treatment for her son, she consulted her colleagues and the doctors at the hospital. At least one other nurse advised her to follow the healer who presented herself outside the ward. Mama Ramadhani’s experience demonstrates how the hospital serves as a site for the negotiation of afflictions and medicines, rather than as a separate sphere of therapeutic practice. A healer approached her while she was in hospital.
A body with a sorcerer’s mischief (wadudu) could not accept the pharmaceutical prescribed by the visiting German doctors. Her son’s body required both traditional and modern medicines. He did not have separate afflictions or affections with distinctly traditional and biomedical causes as much as his affliction struck a complexly configured body. Treatment for his acute condition required articulation of multiple spheres, the effects of which had to be carefully coordinated. Mama Ramadhani did not return to the hospital because the traditional treatment did not work; she returned because the biomedical treatment could only work after the sorcerer’s mischief was removed. The treatment of one body and one affliction required moving between therapeutic spaces. Healers on the hospital grounds. Nurses in the healer’s home. This is not merely a process of moving back and forth between therapeutic options in the desperate hope that one might work. I suggest, as well, that Mama Ramadhani’s experience cannot be best explained as a process of diagnosis by trial and error. She did not seek out multiple treatments for her son to deduce his affliction through the elimination of ineffective treatments. Here the body was multiple. Traditional and modern medicines required coordination in the service of effective treatment.

Nursing neoliberal traditions

The relationship between traditional and modern medicine enacted through nurses’ and nurse’s aides’ pragmatic attention to patients is quite different from the institutionalized forms of pluralism supported by national and international programs. Nursing staffs in the clinic deal less with broad distinctions between traditional and modern medicine than with the immediate and contingent variables of patient history and status. In so doing, they may suggest that a patient see a traditional healer or use a particular kind of traditional medicine; they may facilitate the patient’s temporary departure from the ward between doctors’ rounds; and they may turn a blind eye when herbal medicines are used in the clinic. Nurses and nurse’s aides in Hospital T are cultivating new ways of discerning affliction and coordinating treatment. This process is tenuous, in that it is not institutionalized; rather, it occurs between nurses in informal conversations and between nurses and their patients, kin, neighbors, and friends. These forms of discernment are emerging in response to contemporary clinical conditions, demands for care, and institutional pressures.

The bodily assemblages that nurses and nurse’s aides are enacting are historical. Or, more precisely, they are now becoming necessary in response to particular economic and political changes.

The acts of distinguishing and ordering traditional and modern therapies are, of course, not new. Both missionary and colonial doctors and nurses confronted a diverse range of healing practices when biomedicine expanded into Africa. These encounters were complicated; they motivated scattered instances of incorporation (e.g., healers drawn into early outpost dispensaries as dressers or assistants, midwives trained by nursing sisters, hospitals and dispensaries sprinkled with holy water to prevent witchcraft and sorcery). John Iliffe (1998) has argued that, since the early expansion of biomedicine in colonial Tanganyika, medical practitioners have encountered local healing practices in the bodies of patients filled with and reacting to organic medicines and in the expectations of patients and their families. Yet, today, there is a new urgency to the coordination of traditional and modern medicine.

As medicine moved from the purview of missions and colonial powers to the responsibility of national governments, national health care systems were required to meet the needs of all citizens. In fact, both clinical care and public health became moral imperatives for a modern citizen. In Tanzania, through the 1970s and early 1980s, President Julius Nyerere aimed to build and maintain a dispensary within ten kilometers of every person in the country. Staffing this expanding biomedical network was a problem from the beginning, however. Acknowledging that many newly independent nations faced such labor shortfalls, the WHO, during the 1978 Alma-Ata conference, proposed conceptualizing traditional healers as a resource. Healers in developing countries could be harnessed, the WHO suggested, to help resolve the labor shortage as health care delivery systems moved from the limited colonial and mission care to the broad-based, public care of independent national governments. The WHO also encouraged developing countries to utilize traditional healers in their efforts to meet international health development goals, such as Health for All by the Year 2000. Throughout the socialist period (1964–85) in Tanzania, however, most efforts to institutionalize traditional medicine focused on the scientific investigation of plant, animal, or mineral products and the registration of self-identified traditional healers. In other words, it depended on the expertise of scientists and bureaucrats. Since the late 1980s, neoliberal reforms have placed new pressures on clinical staff and have driven the development of novel forms of nursing expertise.

Accepting the conditions of the IMF has meant adopting various structural adjustment programs that have required instituting medical cost-sharing measures and other policies that challenge health care provision. As the
demands of global economic governance erode the state’s ability and commitment to providing health care for all, the ministries of health in Tanzania and other African countries have turned to traditional healers and traditional birth attendants with renewed interest. Nurses are central to these efforts. They explicitly coordinate healers’ care with that of the hospital, through training workshops around issues such as attending home births and caring for people with HIV/AIDS. The institutional salience of traditional medicine and healers is eliciting new configurations of care. To attend to this historical shift, I argue, anthropological analysis needs to move from examining the coexistence of multiple bodies (“medical pluralism”) to examining the production of the “body multiple” (Mol 2002) across diverse spaces of care and through broad therapeutic ecologies.

Although boundaries between traditional and modern medicine have never been clear, the passion and will that drove investments in the purification of these two modes and that generated them as intelligibly distinct analytic categories is fading. Bodily uncertainty is now implicated in the contemporary political and social insecurities of “third world” capitalism (Livingston 2005). The modernist dualisms sedimented in the gates of the hospital and the prejudices of the nurses are being overwhelmed by the demands of everyday practice. Nurses are compelled to coordinate traditional medicine not only with but also within biomedicine. The implications of this change are both subjective and ontological. In contrast to Steven Feierman’s (2000) description of the movement between therapeutic experts as a process of “diagnosis by addition”—experienced as a spiraling out, a movement from one or another starting point toward a conclusion—such movement is now experienced as a process of discerning the ways in which inequities, emergencies, and alterities are deeply implicated within one another. Everyday efforts at comparison are being replaced by everyday efforts at articulation. In the economic and administrative milieu that marks neoliberal Tanzania, movement coordinates different versions of bodies and afflictions, allowing them to be read through one another.

Nurses are at the heart of this change, as they dominate the administration of hospitals in Africa, taking the brunt of the weight imposed by the constraints of current economic regimes while simultaneously facing obligations to patients, neighbors, and kin. These obligations compel an object of attention and care that can hold together the ground on which the nurse and the nurse’s aide know themselves to be caretakers. Called on to attend to those entering the hospital for relief or transformation, nurses forge bodily assemblages that allow them to respond, to act, and to care within the constraints and desires, the compulsions and resistances, and the interruptions and interferences of clinical work.

Notes

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1. Referring to “traditional” and “modern” medicine is a historically fraught proposition. “Traditional” medicine emerged in relation to the spread of biomedicine in eastern Africa. It has served as a catchall category indexing forms of healing, kinds of affliction, and types of experts that were not officially included in missionary or colonial health care. Traditional medicine, then, is all that is not modern medicine, or biomedicine. This initial collapsing of diverse healing practices into the category of traditional medicine undoubtedly did violence to forms of difference that were salient in colonial Tanganyika, but today references to traditional medicine are widespread. As the category has gained epistemic and bureaucratic weight over time, healers themselves have come to organize around their common commitment to and practice of traditional medicine. The contemporary life of the phrase traditional medicine does not make such references any less fraught, but it does make them important sites of inquiry.

2. Sjaak van der Geest has promoted the anthropological study of hospitals, what he calls “hospital ethnography,” to highlight how biomedical practice differs cross-culturally. See, for example, the special issue on hospital ethnography edited by van der Geest and Kaja Finkler (2004).

3. By elucidating the generative capacities of double binds, Kim Fortun (2001) initiates an important discussion about the forging of communities, experts, and objects of knowledge within the complex asymmetries of postcolonial life.

4. This account builds on recent studies that complicate medical pluralism, rejecting too-neat, too-clean, and often ahistorical descriptions of discrete medical systems between which patients or their kin choose (Poole 1994). For example, see Adams 2001; Cohen 1998; Farquhar 1994, 2002; Langford 2002; Lock 1993; Pigg 1997, 2001; Scheid 2002; and Zhan 2001.

5. Perhaps such interruptions are particularly visible in Tanzania. References to traditional and modern medicine in Kiswahili connote varied forms of the “traditional” (asili, jadi, and kienyeji) as dynamic and shifting, whereas the “modern” (kisasa) connotes the historically flat space of the “now.” In contrast to the presentist notion of “modern medicine” (dawa za kisasa), each of the Kiswahili phrases referring to traditional medicine (dawa za asili, dawa za jadi, and dawa za kienyeji) connotes a differently generated temporality. Asili carries with it a sense of that from which things derive, an origin. It is invoked to describe a base, basis, or foundational elements. In this context, asili is a denominator in mathematics. In contrast, jadi evokes a sense of ancestry, genealogy, descent, and lineage. Jadi has some resonance with mila, or custom. Jadi speaks most eloquently to the multifarious hybridity of any object as it moves through generations. The third term glossed in English as traditional is the place-oriented kienyeji. Kienyeji implies
locality—tradition in the sense of that which has come to distinguish and define an area. Sometimes, when *kiyeyi* is used in reference to healers or medicines, it sits a little sourly in the speaker’s mouth. Tone or context can tinge it with the flavor of primitiveness or backwardness, connotations that make anthropologists cringe. Yet, to others, this place-based character, and the density of connections that it captures, is not a problem but a strength. None of these terms (necessarily) define an unchanging past; rather, they evoke a sense of movement. *Kiyeyi* implies the growth of, and growth out of, a place. *Jadi* captures development through generations. *Asili* suggests derivation—transformation from one state to another. These three expressions of “tradition” are about traveling. This travel is not limited to the slippery displacements of scientific universals. There are in these words many ways to travel.

6. Others have referred to such interferences. See, in particular, Semali 1982:33, 41, 63 and Good 2004:32, 49 n. 18.

7. In this article, my references to “nurse’s aides” are to employees hired as maternal and child health (MCH) aides and medical attendants.

8. The anthropological literature on medicine, particularly by scholars working on Ayurveda and Chinese Medicine, offers different resolutions to the problem of accounting for the ways in which bodies are constituted and cared for as assemblages. Jean Langford (2002) refers to “fluid bodies” that emerge within the context of postcoloniality and its ambivalences. Judith Farquhar (2002) unsettles the string of dichotomies attached to distinctions between traditional and modern medicine by writing of “historical bodies.” Volker Scheid (2002) approaches his description of contemporary Chinese Medicine through a notion of “synthesis,” which is particularly compelling if one mulls over Hegel’s version of synthesis as a new idea that resolves conflict between the initial proposition (for the nurses, traditional medicine). Ayurveda and Chinese Medicine, however, have been entangled with nationalist projects and propelled by state investment in ways that contrast sharply with the situation in Africa. For this reason, I draw most explicitly here on the notion of “articulation” that has been elaborated by science-studies scholars, who emphasize its dual meaning—to make intelligible and to join. Joining—as an elbow might join different parts of the arm—captures both the residual distinction through a spatial metaphor (there must be something on either side of the joint) and the sense that something whole is at stake.

9. Contemporary studies of nursing in Africa, including this one, owe a great deal to Nancy Rose Hunt’s work (1999) on nurses as “middles,” that is, as figures who mediate alterity within the clinic and within the patient as well as coordinate the different foci of concern that arise in African hospitals.

10. During this period, the nursing staff consisted primarily of women. The district nursing officer and one other senior registered nurse were men.

11. I thank Marjorie Mbilinyi, the head of the analysis, research, and publications (ARP) section of the Tanzania Gender Networking Programme (TGNP), for sharing her summaries of these larger TGNP discussions with me during our conversations in February 2008. For analysis of neoliberal reforms in health and other sectors in Tanzania, see Chocache and Mbilinyi 2003.

12. I conducted interviews, ranging from one to two hours, with 26 members of Hospital T’s nursing staff. These 26 nurses, MCH aides, and medical attendants included all staff members who were scheduled in the regular nursing rotations between April and July 2003. Through the interviews, I collected three main kinds of information: (1) staff members’ personal medical histories as well as the histories of those relatives they helped to seek treatment; (2) their professional history, including specifics about their training; and (3) their role in mediating decisions about and use of traditional medicines.

13. For reasons of confidentiality, I have changed the names of any details that easily identify my interlocutors.

14. These numbered notations refer to the confidential code assigned to each tape-recorded interview with clinical staff in Hospital T.

15. Conversations occurred primarily in Kiswahili but included some words or phrases in local languages. All translations are my own.

16. *Kafunga*, to close, is a Kiswahili verb often used to refer to workings of medicine.

17. It is interesting to note that stories of herbal treatments administered through nasal-gastric tubes circulated among healers and patients. In the stories I heard healers tell, the afflicted person always recovered as a result of the treatment. I found it difficult to assess how often medicine was administered through feeding tubes as well as the resulting survival rate; however, the iconic nature of tubes and drip lines in marking the intersection of traditional and modern medicine was clear.

18. Mama Tatu stated that they are here inside because they steal away. They go and pick up traditional medicines and return to the ward with, for example, an [herbal] ointment. They hide and smear it on the patients when the nurse is gone. When we discover this we ask them why the patient is white, they say, “I don’t know.” Medical baths [however] we cannot detect because it resembles the [plain] water for bathing.

19. The Bantu word *Mungu* has acquired layers of meaning through encounter. Today both Christians and Muslims use it to refer to God or Allah, but J. A. R. Wembah-Rashid (1974) argues that, in southern Tanzania, it is also an older term referring to the place to which offerings and sacrifices ascended.

20. In her account of her son’s illness and his therapeutic itinerary, Mama Ramadhani states that the healer who told her about the mashetani cried. Such crying is sometimes seen when healers are “diagnosing” an affliction. As a manifestation of the healer’s communication with ancestral shades, spirits, and other nonhuman agents, it is cited as a sign of legitimacy.

21. Users fees have also made it more difficult for people to afford biomedical care. Some scholars have speculated that such fees will “push” people to use traditional healers. Although healers do require compensation, Susanna Hausmann Muela and colleagues (2000) have written convincingly on the different kinds of resources that may be mobilized for traditional versus hospital care.

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