

Thesis Submitted for the Research Masters in African Studies,
Leiden University

Perceiving Epilepsy:

Interpretations of *Kifafa* in Kigamboni, Tanzania

by Marina Denisenko

Supervised by Prof. Rijk van Dijk (ASC Leiden),

Prof. Koenraad Stroeken (Ghent University)

Leiden, 2013

Contents

Acknowledgements	3
Introduction.....	5
Theoretical framework.....	12
Uncertainty.....	12
Fuzzy Set Theory.....	14
Tradition and Modernity	15
Epistemology.....	19
Structure and agency debate	21
Stigma.....	23
The Field and Methodology	28
Kigamboni as location and space	28
Practicalities	29
Methodology.....	30
Techniques and methods	30
Ethical concerns.....	37
Chapter 1. Ambiguities of <i>uganga</i>	38
Migrations and tribal wars in Tanzania	39
The Ngoni invasion and caravan trade.....	39
The colonial period.....	41
Intstitutional development	43
Nyerere’s Tanzania.....	43
Capitalist Tanzania.....	46
Medical pluralism?	48
Conclusion	50
Chapter 2. Etiological interpretations of <i>kifafa</i>	53
People who are not directly affected by <i>kifafa</i>	55
Analyzing the population.....	55
People and perceived causes of <i>kifafa</i>	58
People who have <i>kifafa</i> and their caregivers	67
<i>Waganga</i> of Kigamboni.....	68
Conclusion	69

Chapter 3. <i>Kifafa</i> and <i>Degegede</i>	72
Symptoms and perceived etiology	72
Treatment choices for <i>degegede</i>	76
Case studies of <i>degegede</i>	78
Conclusion	85
Chapter 4. Treatment choices	88
Semi-structured survey participants	88
Biomedicine as first resort.....	89
Traditional medicine as first resort	90
Traditional healers and their treatments	92
Biomedical approach and Dr. Sayan Saleh	98
The treatment choices of people with <i>kifafa</i>	99
Conclusion	101
Chapter 5. <i>Kifafa</i> -related stigma?	105
Semi-structured survey participants	107
Contagious.....	107
Not contagious	108
People with <i>kifafa</i> and their social experiences.....	109
Stigma?	115
Conclusion	117
Conclusion	120
List of abbreviations	129
List of tables, maps, graphs and illustrations	130
Glossary	132
Appendix.....	138
The semi-structured questionnaire.....	138
Bibliography.....	140

Acknowledgements

A lot of work has been done and now it is time to say “thank you” to all those people who have been with me every step of the way giving guidance and advice and always supporting. First of all, I would like to thank the Minister for Education, Culture & Science of the Netherlands for awarding me with the Huygens Scholarship, which paid for my studies and provided a generous monthly allowance. I wouldn’t have been able to do my research in Tanzania without this funding.

I am equally grateful to my supervisors Prof. Rijk van Dijk from the African Studies Centre in Leiden and Prof. Koenraad Stroken from Ghent University. Their deep knowledge, excitement about my research, valuable feedback and recommendations kept me inspired and provided with fascinating challenges. I thank Rijk for our lengthy discussions and interesting ideas, for guiding my writing into the proper direction and making the whole process comprehensible, for reading my chapters and commenting on them. I say “thank you” to my second supervisor Koen Stroeken for valuable feedback he gave for my research proposal, advice I received in regard to the fieldwork process, essential literature he recommended, and for managing to supervise me just through e-mails as, unfortunately, we didn’t have a chance to meet in person.

I would like to thank my program coordinator Azeb Amha for her guidance, help and friendly concern about my fieldwork and my health. I also thank the motivating lecturers of the African Studies Centre and other departments of Leiden University, especially Prof. Peter Pels for his extremely useful feedback, valuable advice and interest in my research. I am also very grateful to Dr. Jan Jansen for putting some structure into my ideas and for influencing my writing style in a positive way.

I am very grateful to head of the Russian-Tanzanian Cultural Centre Alexander Zdanevich and to his wife Natalya, who kindly hosted me for the whole time I was in Tanzania free of charge. If it weren’t for their assistance, hospitality, advice, support and pleasant company, my stay in the country would have been much less enjoyable. Thank you for our intellectual conversations, lifts to shops, dinners and the time you spent with me; thank you for cheering me up with jokes and humor. I truly appreciate everything you did for me. I also thank the staff of the Centre for making my stay comfortable and for being so eager to discuss *kifafa* with me.

I thank my research assistant Johnny Shabani for showing me around Kigamboni, introducing me to people as his friend, helping me with every aspect of my fieldwork. His support of my research, explanatory remarks and friendly attitude made my days in Kigamboni productive and pleasant. I am

also grateful to Sheha and Hadija, who became my friends and took part in my survey; their hospitality will not be forgotten.

I am very grateful to my classmates, especially Katja Kirchner and Roeland Hemsteede, for always being there for me, distracting me with jokes, encouraging, believing in me, giving advice and sharing their fieldwork experiences. I thank my mother for her patience, care, encouragement and unconditional support; I say “thank you” to my Russian friends who managed to keep me positive and motivated from so far away. The warmth, care and kindness of my family and friends made my research not only possible but productive as well. I thank you all!

Finally, I thank my informants and Tanzanian people who have been so kind to me and unselfishly helped me to do the research. I am still touched and humbled by your hospitality, cheerfulness, and heartfelt and sincere desire to participate in the survey or be interviewed. I hope that this thesis will contribute to the bulk of knowledge about *kifafa* and epilepsy so that someday this condition will be completely cured. I also hope that I’ve made the voices of my informants heard with this paper, which is also a form of my eternal gratitude to them. I thank you all for making this research possible and wish you a pleasant time reading this thesis.

When I was ten all I knew was that I hated the weird words used to describe whatever it was that was wrong with my brother—to this day I think it all happened because he was overtaken by evil spirits that got loose in that haunted house ride at the carnival that summer. It's easier for me to make sense of it that way than it is for me to face the other way—reality. And yet, those evil spirits that were unleashed—be they fake entities from a stupid carnival ride, or cruel malevolencies from dark spiritual chasms of our universe—have stayed with me all these years.

Tim Cummings, ORPHANS stories

Introduction

The illness of epilepsy has been known to the mankind for centuries; much effort has been put into researching its obscure etiology. Up to this day, for six out of ten people the cause of this disease is unknown (Hicks, 2009). Biomedicine has been trying to define epilepsy in clear terms in order to tackle the field of ambiguities surrounding this condition. Eventually, epilepsy was determined as a chronic noncommunicable neurological disorder characterized by recurring seizures, during which some people lose consciousness and control of bowel and bladder function (WHO, 2009). In 1997 during the XXII International Epilepsy Congress, WHO joined hands with the International League Against Epilepsy (ILAE) and the International Bureau for Epilepsy (IBE) and launched the “Out of the Shadows” campaign, which was aimed at raising global awareness about epilepsy and rendering practical assistance to countries, chapters, governments, and departments of health (Reis & Meinardi, 2002: 33). All the above-mentioned institutions are inherently biomedical and see epilepsy as a disease and as a problem that has to be solved. The core of the problem is not only the detrimental effect this illness has on health, but also the stigma and discrimination, which go hand in hand with epilepsy, according to WHO (WHO, 2009). But how do lay people in Tanzania see epilepsy? Do they think of it in biomedical terms? Do they perceive it as stigmatizing?

Before going to Tanzania, I did a preliminary internet research on perceptions of epilepsy to get an idea of the meanings assigned to this illness on the ‘macro-level’. I found that in all the sources (the WHO website, various blogs, newspaper articles, NGOs’ and epilepsy clinics’ websites, YouTube videos, etc.) people with epilepsy were presented as living lives of ‘humiliation and fear’ (Jilek-Aall, 2010) and suffering from social exclusion and stigmatization (See for example: WHO, 2009).

In the academic literature on epilepsy the concept of stigma is used as auxiliary, often becoming a lens through which this illness is looked upon; stigma is taken for granted, assumed and presupposed. Scholars unanimously acknowledge that epilepsy can cause stigma, be it in Tanzania

(Jilek-Aall, 2010; Winkler et al, 2012, 2010 (a), 2010 (b), 2009; Rwiza et al, 1993 (a), 1993 (b); Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001), China (WHO, 2009) or elsewhere (Giel, 1968; Jilek, 1979; Andermann, 1995; Kendall-Taylor, 2008). Very few papers address the concept of 'stigma' in a thorough and comprehensible way; the article by Reis & Meinardi (2002) is a remarkable exception. In this thesis I will argue that the stigma rhetoric is used by the biomedical institutions as a means of problematizing the illness of epilepsy and drawing public attention to it. Fighting this disease not only within the healthcare domain, but also on the social level, the institutions fall into their own trap producing stigma while trying to eliminate it.

In the language of Swahili, which is spoken throughout most of the East-African countries, the biomedical illness called 'epilepsy' is known as '*kifafa*'. Interestingly, this word belongs to the 7/8 noun class, or the so-called 'ki-class', which is the class of things in general, little things and marginality, both social and physical (Gromova, 1995). Such illnesses as diabetes (Sw., '*kisukari*'), tuberculosis (Sw., '*kifua*'), cholera (Sw., '*kipindupindu*') and people with physical or social 'disabilities' like *kipofu* ('a blind person') and *kijakazi* ('a slave girl/maid') belong to the *ki*-class. The language itself is a powerful tool of emphasizing the differences between the healthy and the diseased; at the same time the speakers simply use the words without thinking twice about the grammatical nuances. Thus, giving us so many fascinating opportunities (e.g. understanding and sharing), the language yet limits us to its own particular expressiveness and logic. Indeed, *Die Sprache spricht*.¹ Likewise, by attributing certain conditions to a specific word or term, we exclude the potential multiplicity of meanings. In other words, by saying 'epilepsy' we are reducing the epistemological scope of '*kifafa*'.

In the present thesis I will abstain from using the word 'epilepsy', which is insufficient for explaining the perceptions of *kifafa* in Kigamboni, where I conducted my research. Kigamboni is a peri-urban area and an administrative ward in the Temeke district of the Dar es Salaam Region of Tanzania. I chose this particular area for my research due to its peri-urban nature, proximity to Dar es Salaam and ethnic plurality. One of my goals was to see if (and if yes, then how much) the perceptions of and healing epistemologies related to *kifafa* in a peri-urban area, which (I supposed) was influenced by the biomedical discourse from the city, differ from those of the rural areas, where most of the epilepsy-related research has been conducted (e.g. Winkler et al, 2012, 2010a, 2010b, 2009; Rwiza et al, 1993a, 1993b; Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001).

When writing my research proposal and reading the literature on the topic I also realized that scholars, who published on epilepsy in Tanzania, were mostly interested in rural areas and the

¹ A famous saying by Martin Heidegger, a German philosopher of the XX century. Translated from German as "Language speaks".

Northern part of the country (e. g. Jilek-Aall, 2010; Mushi, 2011), which is why I picked a peri-urban location. Kigamboni seemed like a good choice also because of its ethnic plurality: many people from different parts of Tanzania come looking for employment to Dar es Salaam, work in the city but live in Kigamboni as it is cheaper. All these people bring their ideas and epistemologies with them and share them with the residents of Kigamboni through interaction and communication. So, I was curious to see how people interpret *kifafa* and if the perceptions of this condition produce stigma and/or discrimination.

Most research efforts that have epilepsy as focus are aimed at the medical aspects of the disease such as prevalence, incidence, risk factors and etiology. The literature on epilepsy (not necessarily on *kifafa*, which I will argue is not understood as ‘disease’ in the biomedical sense but rather as condition or even multiple conditions) in Tanzania bears the same trait. It’s a relatively new thing to study the illness from the point of view of the social sciences; and even there ‘the subjective experience of people dealing with illness is often overlooked’ (Andermann, 2000: 169). Andermann notes that most scholars are focused on ‘issues such as coping and adjustment to seizures, individual and family reactions to the diagnosis, employment or the rehabilitation, safety issues, as well as lifestyle modifications, including coping with driving restrictions’ (2000: 171). The research on epilepsy in Tanzania is mostly conducted and to some extent even monopolized by neurologists, who use the quantitative methods (e. g. Hunter et al, 2012; Winkler et al, 2012, 2010a, 2010b, 2009; Jilek-Aall, 2010). Likewise, most publications focus on the epileptic patients, who attend a particular biomedical institution (a hospital), which introduces a certain selection bias, acknowledged, though, by the authors (e. g. Mushi, 2011: 342). Keeping that in mind, I didn’t base my fieldwork in biomedical or traditional healthcare facilities, but visited patients in their homes.

My research was qualitative at large, though I used a survey as well. This approach is very much in line with Adermann’s argument that ‘the thorough understanding gained from a detailed and rigorous analysis of a small number of individuals who can express themselves in their own words is balanced against issues of selection bias and statistical significance that are possible only when working with larger numbers, at the expense of individual experience’. She then goes on to say that ‘both quantitative and qualitative methods provide important information about two sides of the same coin – they complement each other and should be used concurrently’ (2000: 171). Thus, the use of the two methods for researching *kifafa* experiences in Kigamboni makes for the innovative aspect of my work.

As for the academic and social relevance, my thesis will contribute to the uncertainty, healing epistemology, tradition/modernity, gender, stigma and some other debates, while also adding to the

bulk of literature on the social aspects of epilepsy. My research also lies within the field of medical anthropology:

Medical anthropology is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and to whom they turn if they do get ill. It is also the study of how these beliefs and practices relate to biological, psychological and social changes in the human organism, in both health and disease. It is the study of human suffering, and the steps that people take to explain and relieve that suffering (Helman, 2007: 1).

The “Out of the Shadows” campaign by WHO could also benefit from my findings, as well as various NGOs fighting epilepsy in Tanzania. The biggest hope is that my efforts won’t be in vain and will in the end have positive effect on the lives of people with epilepsy or *kifafa* and my informants’ in particular.

My main research question and the four sub-questions were very much inspired by the study area of medical anthropology:

◆ How do the people of Kigamboni, Tanzania, perceive and explain *kifafa*?

1. What is the etiology of *kifafa* as perceived by people having it, their caregivers, neighbors, healing specialists and people who are not directly affected by this condition?
2. How do people shape the treatment of *kifafa* and how is the treatment method negotiated (if it is) in the course of treatment?
3. Do perceptions of *kifafa* contribute in any way to the stigmatization of this condition? To what extent is the *kifafa*-related stigma (if it exists) a product of various healing domains?
4. Do the interpretations of *kifafa* (in both public and domestic domains) differ between various gender/age/education, etc. groups?

In the present thesis I will address these four themes and pay particular attention to the multiplicity of interpretations around *kifafa*. I will argue that *kifafa* is not perceived as disease or a bodily shortcoming, which is always the same and can be clearly defined regardless of the body it affects. Thus, using the very word ‘disease’ is problematic; in this thesis I call *kifafa* ‘condition’ or even ‘conditions’ due to vast pluralism of ideas around it. *Kifafa* exists within the healing epistemology, which doesn’t deny any interpretations but accepts all of them as valid and possible. This medical habitus allows for possibilities and leaves room for opportunities by never dismissing, excluding and clearly defining as biomedicine usually does. The changeability and dynamics of this epistemological model are its quint-essential characteristics, which make it flexible and sustainable.

I will argue that *kifafa* is not related to stigma and discrimination quite contrary to what we read in the literature on epilepsy in Tanzania or elsewhere. Furthermore, it is the discursive prevalence of stigma in the academic publications that enables the aspects of stigma to unfold. By determining *kifafa* as biomedical epilepsy many scholars and healthcare workers not only transform the condition(s) into a more convenient and clear (for them) set of characteristics but also label *kifafa* as stigmatizing. Then why do certain health conditions relate to stigma and/or discrimination and others don't? And what is the difference between stigma and discrimination? I will address these questions in detail in the theoretical framework and the fifth chapter of this thesis.

The theoretical section will also help to avoid terminological confusion; there I will discuss the terminology and conceptual framework, upon which my argument will be built. In the '**Field and Methodology**' section I will define my field as geographical location and also as space (cf. De Bruijn & van Dijk, 2012) and address the methodology I was using during my research period. I will describe how I established rapport and how I used and planned my research techniques. I will give my reasons for choosing the methods I chose and also describe their limitations. This will bring me to the actual chapters of the thesis, in which my argument will be constructed.

In '**Chapter 1. Ambiguities of uganga**' I will give a brief history of *uganga* (Sw., 'healing') and its relation to witchcraft in Tanzania. I will also describe the current status of *uchawi* (Sw., 'witchcraft') and *uganga*, the position of the Tanzanian government towards them and show that the discursive uncertainty about *kifafa* has its roots in the past. The first chapter will show that the uncertainties around *kifafa* are akin to the ambiguities of *uganga* and its 'evil' doppelganger *uchawi*. The reader will find that the governments and international institutions have been playing a crucial role in standardizing the healing in Tanzania and, thus, introducing biomedical ideas, etiologies and interpretations, the idea of stigma being among them.

The title of the second chapter talks for itself: '**Chapter 2. Etiological interpretations of kifafa**'. Here I will discuss the perceptions of *kifafa* related to the symptoms and etiology. I will focus on the causes of *kifafa* as perceived by various groups of people, the symptoms of the illness and its 'age range'. I will do that along the age, gender and education lines. I will also describe the opinions of the healing professionals, both biomedical and traditional² on the *kifafa* etiology. Finally, I will address the explanations given by those who have *kifafa* and their caregivers. The aim of the second chapter is to demonstrate the great multiplicity of etiological explanations of *kifafa*, which co-exist with one another in the field of uncertainty. Not a single interpretation is dismissed due to the pluralism of

² The terms 'biomedical'/'modern' and 'traditional' will be discussed in the theoretical section of the thesis.

kifafa itself that can be attributed to various conditions caused by different things but still identified as '*kifafa*'.

'**Chapter 3. *Kifafa and degedege***' will address the condition of *degedege*, which is perceived to be a possible cause of *kifafa* by many respondents. I will describe its symptoms, 'age range', and the medicines used to treat it. In addition to this I will analyze the locally perceived relationship between *degedege*, *kifafa* and biomedical malaria. The third chapter will show how influential the biomedical discourse is in associating *degedege* with malaria but neglecting the vast field of other etiological interpretations of *kifafa*. *Degedege* is not represented as a stigma-related illness in the literature due to its relationship with malaria, which is not seen as causing stigma.

In '**Chapter 4. *Treatment choices***' particular attention will be given to showing what kind of treatment people usually choose to get rid of *kifafa* (and also the treatment that people who don't have it would choose if they were sick). I will also argue that the people of Kigamboni mostly judge the treatment by trial and error. I will also discuss if *kifafa* is perceived as bodily misfortune (as a physical shortcoming having a physical cause or rather as the curse of an evil-doer). Religion also plays its part in the healing process and divination in particular, which I will also touch upon. The aim of the chapter will be to analyze the practical aspects of treating *kifafa* and to see if the practice correlates with the etiological explanations discussed in the second chapter and with *uganga/uchawi* in general. Healers and institutions such as biomedicine and education also play their part in promoting certain treatment types.

In '**Chapter 5. *Kifafa-related stigma?***' I will talk about the relationship between stigma and *kifafa* and analyze what makes certain health conditions stigmatizing. I will address the literature on HIV/AIDS-related stigma to see if any aspects of HIV/AIDS stigma (e.g. labeling, shaming, ostracizing, etc.) reveal themselves in the context of *kifafa*. I will also discuss what various groups of people think about the contagiousness of *kifafa*. How does having this condition influence the social and economic life of the people and the family structure? Is *kifafa* perceived as a strain on the family? All these questions will be addressed in the fifth chapter. I will also continue arguing that the academia, the governments and other institutions are extremely influential in terms of introducing and promoting the idea of stigma related to *kifafa*.

In the '**Conclusion**' I will incorporate all the preliminary conclusions drawn in the previous chapters and come up with a consistent ending, which delivers the promises made in the introduction. I will demonstrate that the ambiguities and multiple etiological interpretations of *kifafa* have their roots in the past and in fact fall in line with the healing epistemology of Kigamboni. *Uchawi* and *uganga* like the two-faced Janus give room for various interpretations, which co-exist together and even make it

possible for the medical habitus to (re)produce itself. The fuzziness and uncertainty around *kifafa* are not problematized by the residents of Kigamboni; ambiguities are perceived as a natural aspect of life.

Pro-biomedical institutions (the Tanzanian government, public education, NGOs, academia, international organizations, etc.), on the contrary, are interested in minimizing the uncertainties and standardizing health-related afflictions. They also play a crucial part in shaping the etiology and even the treatment of *kifafa*; moreover, they introduce stigma into the discourse on the condition(s). Healers are also responsible for popularizing particular explanations and treatment techniques of *kifafa*; they contribute to the fuzziness around *kifafa* in general by using divination, which is individual for every patient. Thus, they provide some certainty for individual clients while the affliction itself remains ambiguous.

I also hypothesize that the more uncertainty there is around *kifafa*, the less likely it is for this affliction to become stigmatizing. Stigma seems more likely to be attached to a condition defined with crisp categories rather than fuzzy sets (see Theoretical Framework). Finally, I argue that the pluralism of interpretations (both around *kifafa* and *uchawi/uganga*) is the vital characteristic of the medical epistemology of Kigamboni.

Theoretical framework

Before constructing my argument I will address some academic debates relevant for my thesis and position myself within these debates. In this section I will also discuss the key concepts that I will use later on, show in which sense they have been used by scholars, and define in which meanings I will be using them. This theoretical framework will be constructed around two major debates relevant for my research: stigma and uncertainty. The former is useful for understanding the processes of labeling, status loss and the driving forces of stigmatization. The latter explains how people deal with misfortune and the uncertainty that it evokes. I argue that as a health-related misfortune, *kifafa* exists in the field of fuzziness. Moreover, this uncertainty makes *kifafa* very hard to stigmatize.

Uncertainty

Anthropologists and social scientists usually conceive of uncertainty as ‘a concept denoting non-recurrent and unpredictable phenomena that are intrinsically difficult to counteract, but affect the lives of individuals or a given group of people’ (Haram & Yamba, 2009: 13-14; see also Jenkins et al, 2005a; Whyte, 1997). Thus, when talking about uncertainty anthropologists usually mean unpredictable and uncontrollable events such as accidents, sudden deaths or severe illnesses. In this case uncertainty refers to particular experiences, while it can also be seen as a state of mind, which is caused by these experiences. According to Whyte (1997: 18), ‘experience is characterized by uncertainty, ambiguity, and contingency’ and uncertainty is ‘not a vague existential angst, but an aspect of specific experience and practice’ (Ibid.: 19). In this thesis I will define uncertainty as a state of confusion and indeterminacy, which comes as a consequence of an unpredictable and uncontrollable experience (in my case health-related misfortune).

An unpredictable event can be explained as an accident caused by random chance or as a deed committed by some malevolent force. In either case people want to make sense of the event and deal with the uncertainty in logical and rational ways (Haram & Yamba, 2009: 14). The processes of analyzing and rationalizing aimed at grappling with uncertainties produce various etiological and causal interpretations. Depending on the perceptions of an individual, there can be two lines of action taken to minimize the risks of mishaps: passive and active. The former implies that the misfortune was due to a chance and thus couldn’t have been avoided. The latter attributes the undesirable event to the work of a malevolent agency and focuses on pragmatic measures to alleviate the adverse effects and prevent any future occurrence (Ibid.). Attempts at explaining and making sense of uncertainty are very pragmatic as their goal is to take control over unpredictable

events and prevent them from happening again (Whyte, 1997: 18-21). Every attempt of managing uncertainty is a quest for certainty and reassurance.

Control and uncertainty are always negotiated within the social relations, which make them very contextual. In the real life people usually have to adjust to a particular situation rather than fully control it. When confronted with indeterminacy, people struggle to influence even if they can't change the course of events completely (Jenkins et al, 2005b: 11). Though fate and chance are known to be irrevocable and irresistible, people treat them as if they were controllable or negotiable in the practice of life. Despite the impossibility of complete clarity, people try to create a certain degree of insurance and security (Whyte, 1997: 18). Science, religion, magic, medicine, witchcraft, divination and other practices confirm the fact that the quest for certainty is a core characteristic of every culture.

Many anthropologists present witchcraft as a means of dealing with uncertainty and as a reaction to inequality, which is associated with modernity. Modernity is supposed to bring clarity and transparency, yet it breeds ambiguity (Sanders, 2009: 93). The resurgence of witchcraft is believed to be causally connected with various misfortunes, be it economic, social or health-related (Comaroff & Comaroff, 1993; Geschiere, 1997; Moore & Sanders, 2001). It sounds like a paradox given the ambiguities and secrecy surrounding magic practices: people address something fuzzy and vague (e.g. witchcraft) in order to alleviate uncertainty. Thus, the quest for certainty often results in doubt and uncertainty just like 'clear' and 'rational' modernity brings about more of the 'unclear' and 'irrational' witchcraft. In the first chapter of this thesis I will argue that the ambiguities surrounding healing (Sw., '*uganga*') and witchcraft (Sw., '*uchawi*') are not problematized by the residents of Kigamboni; moreover, these uncertainties are integral characteristics of the medical epistemology.

The efforts to manage health-related misfortunes draw on multiple strategies and practices, which are supposed to reduce uncertainty. When affected by an affliction, people try to explain it and come up with etiological ideas as well as possible treatment plans. These days there are various treatment techniques at the disposal of an average individual – from biomedicine and pills to religious healing, rituals and magic. Due to the plurality of medical systems people can shift from one domain to another and switch between treatment methods. The availability of alternatives and the room for choice contribute to further uncertainty about which treatment strategy is the right one (Jenkins et al, 2005b: 11).

Agency can be seen as a supportive concept of uncertainty; at the same time it can be opposed to it. The choices we make and execute in order to deal with, explain and minimize uncertainty are manifestations of our agency (Haram & Yamba, 2009: 24). Thus, people are not entirely influenced by

their cultural background, medical epistemologies and authoritative institutions; there is always room for individual decisions and choices. At the same time biomedicine attempts to impose rationalization and a particular cultural script legitimized by science and research in order to retain authority in the matters of health (Jenkins et al, 2005b: 14). Traditional medicine is also interested in being a custodian of clarity and the ultimate provider of certainty within healthcare. In this respect healers are interested in the fuzziness of various conditions and misfortunes; in fact, this very ambiguity justifies their professional activities aimed at alleviating uncertainty. In the fourth chapter I will demonstrate how *waganga* and biomedical doctors contribute to the obscurity around *kifafa*.

We have established that in case of a health-related misfortune people usually try to introduce some order into the situation, find an explanation and reduce uncertainty surrounding the affliction. The responses to the unfortunate circumstances vary greatly in every particular situation and are as much driven by the individual agency as by the local epistemology and authoritative institutions. In this respect, biomedicine can be seen as a state-sponsored attempt to control uncertainty and ‘create a predictable social environment through rational treatments and public health’ (Jenkins et al, 2005b: 17).

As opposed to biomedicine, traditional medicine is interested in keeping particular conditions ambiguous so that it can alleviate uncertainties individually. In the case of *kifafa* the healers benefit from the fuzziness and multiple interpretations of this misfortune; they render some certainty to their clients through divination in every particular case while the affliction itself remains obscure and ambiguous (see Chapter 4). Biomedicine attempts to clarify the misfortune and turn it into a number of symptoms referred to as ‘disease’. However, ‘attempts to control, reduce or remove uncertainty may actually lead to the generation of further uncertainty or the accentuation of existing uncertainty’ (Jenkins et al, 2005b: 17).

Fuzzy Set Theory

Fuzzy set theory was developed within phenomenology by Lotfi Zadeh (1965; Yager et al, 1987) and despite its analytical value has been overlooked by anthropologists (Laughlin, 1993: 17). This theory is very closely related to the concept of uncertainty as it tries to grasp the mechanisms of perceiving and categorization. As Zadeh described his approach, ‘the theory of fuzzy sets is, basically, a theory of graded concepts – a theory in which everything is a matter of degree or, to put it figuratively, everything has elasticity’ (Zimmermann, 1991: xv). In other words, everything is uncertain in this theory.

The central concept in fuzzy set theory is fuzziness developed by Zimmermann (1991), Klir & Folger (1988), Smithson (1987), Kaufmann (1975), Dubois & Prade (1980), and some other scholars. Fuzziness refers to an 'easing of restrictions upon membership in a category – categories being cognitive classes of objects, "which are considered equivalent"' (Laughlin, 1993: 18). The belonging to a particular category is not clear-cut but fuzzy, meaning that every object may be *more or less* a member of the category (Ibid.). Fuzzy reasoning or logic can also be called approximate reasoning, which is characterized by limited certainty, never being completely exact or totally inexact (Zadeh, 1975: 1).

In this thesis I will use Laughlin's definition of fuzziness: fuzziness refers to 'the imprecision, ambiguity, relativity, vagueness, elasticity, incompleteness, and possibility that is a quality of categories and propositions in much of human thought' (1993: 18). In this respect, fuzziness is very much a product of uncertainty and may be called cognitive uncertainty, as both these conditions derive from experience (Laughlin, 1993: 22; Whyte, 1997: 19). Fuzziness is dichotomized with the concept of crispness, which refers to precisely delimited, exclusive, inelastic, non-ambiguous set membership (Kir & Folger, 1988: 3). Basically, crispness is very similar to certainty, the only difference being that certainty does not refer to the cognitive process of categorization but rather to a state of mind.

Laughlin (1993: 23) argues that 'the more a state of consciousness is oriented on direct experience, the fuzzier will be the categories informing experience'. He based this hypothesis of 'the experiential proximity' on stating that every moment of consciousness is organized around an object (process, feeling, image, thought, event, experience, etc.). Some states are organized around categories of thought (e. g. abstract thinking, logic), some around sensorial activities (e. g. divination, trance, sensory experience). I will argue that *kifafa* denotes a fuzzy set for the residents of Kigamboni, who are driven by experience in situations of uncertainty brought about by health-related misfortunes.

Tradition and Modernity

I include the tradition/modernity debate into this section because, as we previously established, modernity claims to bring rationality and clarity, while research shows that it breeds uncertainty and multiplies witchcraft. The very concepts of tradition and modernity are very fuzzy. Without addressing this debate it is impossible to understand biomedicine and traditional medicine as the means of grappling with and managing uncertainty in the field of health-related misfortunes. By providing a (supposedly) transparent and rational strategy of dealing with uncertainty, minimizing it and taking it under control, modernity stumbles and produces more uncertainty, ambiguity and

fuzziness (Sanders, 2009: 93). Thus, it is useful to look at the tradition/modernity debate to get insights on how different cultures try to manage health-related uncertainties.

In the studies related to health, illness and misfortune the terms 'modern' and 'traditional' have been used to distinguish between the two healing domains: biomedicine and traditional medicine. The former is concerned with treating patients as physical bodies by using material substances (Langwick, 2011: 23). The latter uses *materia medica* as well, but the object of treatment is not confined to the patient and his body. Traditional medicine is eliminating malevolent forces that cause the illness or condition, and those forces are usually found outside the patient's body (e. g. witchcraft, curse, incest, kin, breaking a taboo, and spirit possession, etc.) (cf. Ademuwagun et al., 1978; Giles, 1987, 1999; Devisch, 1993; du Toit & Abdallah, 1985; Feierman & Janzen, 1992; Janzen, 1982; Turner, 1967, 1968, 1975). The majority of the Swazi, for example, refer epilepsy to the 'spirit possession caused by evil medicine' (Reis, 2000: 61). Berglund describes traditional medicine as 'a struggle of establishing and maintaining life' (Berglund in Jacobson-Widding & Westerlund, 1989: 109).

The two healing domains were analytically separated from one another in both their approaches of providing cure and the objects of treatment. The border between traditional and modern medicines was established by the very terms describing them. Traditional medicine suggested 'discreet and enduring practices associated with social groups demarcated by common residence, descent, language, social status, and/or religious belief and distinguishable from other discreet and enduring practices associated with other such groups' (Luedke & West, 2006: 4-5). Dynamism was thought to be found in modern medicine only, while traditional healing was static.

The dichotomy between 'traditional' and 'modern' dates back to the colonial times and comes about largely through the interaction between the European colonizers and the local populations of the colonies. One of the main features of modernity according to Cooper (2005: 113-114) is a 'powerful claim to singularity', which relates to both space that is 'Europe' and the time that is modern or 'modernity'. Thus, modernity relates to a very particular location in a very particular period of time, which is characterized as dynamic, progressive, civilized, and prone to change. On the other side we find tradition, which is everything that modernity is not: non-European, uncivilized, backward, static, primitive, and atavistic.

The European claim to be 'forward' while others were lagging behind posed a lot of questions for historians, who were struggling with redefining the 'non-modern' periods of the world history (Benite, 2011: 639). The notion of progress is closely related to the tradition/modernity debate, being a twin brother of modernity: these two notions often originate one from the other. This

relation is yet problematic as there is no analytical tool to define what is universally progressive or regressive (Ibid.). Nevertheless, modernity was 'framed not only as a powerful argument about modernity's own greatness as a singular European period, but also as an argument about the degeneracy of other times and places – a claim that later became an assertion that non-European societies were not moving forward' (Ibid.: 642).

In the years following the decolonization scholars (of both European and non-European origin) were trying to reassess histories of the non-European countries by looking for the modernity elements (e.g. public sphere, civil society, 'incipient capitalism') in their past (Ibid.: 644). But not so long ago these efforts 'dead-ended, because of either theoretical exhaustion or empirical fatigue resulting from the inability to produce a "sufficiently European" instance of modernity' within a non-European historical experience (Ibid.: 645). Since then the studies were focused on the local modernities defined by internal histories and not by the European model. This meant rethinking the whole concept of modernity and pluralizing it: there was Chinese modernity, Indonesian modernity, African modernity, etc. (cf. Woodside, 2006: 1).

However, the multiplication of modernities robbed the term of its meaning:

The concept of modernity, multiplied, therefore runs the gamut, from a singular narrative . . . to a word for everything that has happened in the last five hundred years (Cooper, 2005: 127).

On the other hand, Benite argues (2011: 650), the new approach to modernity as something global (not Eurocentric) has the merit of not putting different histories vis-à-vis European model. Thus, over the years there has been a shift from modernity as singularity to modernity as multiplicity.

No wonder that the term 'traditional medicine/healing' has been criticized by many scholars (e. g. Feerman, 1985: 110-112; van der Geest, 1997: 904) on the ground that one can see broad regional exchange of healers and their substances and practices, while the terms 'traditional' and 'modern' suggest that there are two mutually exclusive healing practices. At present it is acknowledged that tradition is dynamic, and its very existence depends on its historical dichotomy of modernity (e. g. Pigg, 1996). In other words, modernity is defined through negation of tradition and vice versa; should one of them disappear, the other will follow. The border between traditional and modern medicines becomes less visible due to the constant inter-connections between the two domains.

The dualism of tradition and modernity is questioned by Kleinman (1980: 49-70) who suggested distinguishing between at least three sectors of healthcare: the popular sector, the folk sector and the professional sector. The popular sector is the unprofessional domain of healing, which includes self-treatment, self-medication, advice or treatment given by a non-professional (e.g. relative, friend,

workmate, etc.) among other things. The folk sector is basically the same as ‘traditional medicine’, which is not included into the official medical system. The professional sector is Western-like legally sanctioned domain of healing, also known as biomedicine.

Yet, the attempts at crafting a new terminology to describe healing failed when the confused audience³ demanded to decode the new terms and ‘to confess that it [was], after all, “traditional medicine” that [was being talked] about’ (Luedke & West, 2006: 5). Despite the shortcomings of the terms ‘modern’ and ‘traditional’, they have been used for a long time and became part of social reality:

On the one hand, the narrative of modernization was always bad social science; it was (and is) a myth...resting on fundamental misperceptions about the modern history of urban Africa. But, on the other hand, the myth of modernization (no less than any other myth) gives form to an understanding of the world, providing a set of categories and premises that continue to shape people’s experiences and interpretations of their lives (Ferguson, 1999: 14).

For the sake of convenience, I will use the term ‘biomedicine’ to describe the healing domain, which is also called ‘modern medicine’ in academic literature. I find Langwick’s definition of biomedicine very appropriate for this thesis: *biomedicine is a healing practice, which is concerned with treating patients as physical bodies by using material substances* (2011: 23). *The healing domain that uses materia medica as well, but the object of treatment is often supernatural and is not confined to the patient and his body* will be defined in my paper as ‘traditional medicine’. Thus, traditional medicine goes beyond treating the patients’ bodies; it is relational in nature and places the individual in a set of relationships with the social and supernatural. Biomedicine and traditional medicine are not opposed to each other; rather they are interconnected and complementary. Patients seeking treatment do not necessarily distinguish between the two healing practices.

In the present thesis healing practitioners who mostly work within the biomedical domain will be referred to as ‘doctors’. The traditional medicine professionals will be called ‘healers’ or ‘*waganga*’ (Sw., pl.: ‘doctors’, ‘healers’; sing.: ‘*mganga*’). In Swahili the word ‘*mganga*’ is used to refer to any healing specialist (both biomedical and traditional), while the expression ‘*mganga wa kienyeji*’ (Sw., lit.: ‘native/local healer’) refers to traditional medicine practitioners only. For the sake of convenience I will use the shortcut ‘*mganga*’/‘*waganga*’ do define traditional healers.

³ Luedke & West mean their readers and colleagues here

Epistemology

I will use the term 'epistemology' to describe the healing system of Kigamboni. 'Epistemology' is a term taken from philosophy's terminology and now widely used by social scientists. The general meaning of epistemology is 'knowledge', 'understanding' or, as Toren & Pina-Cabral put it, 'what it is to know' (2011: 2). Epistemology is understood as a system of perceptions, interpretations and experiences built around a particular sphere of life (ex.: healing, education, marriage, etc.).⁴ To some extent, the meaning of the term is very close to Bourdieu's habitus:

The habitus is the product of the work of inculcation and appropriation necessary in order for those products of collective history, the objective structures (e. g. of language, economy, etc.) to succeed in reproducing themselves (Bourdieu, 1977: 85).

Within medical anthropology the term 'epistemology' is used by Koen Stroeken (See for ex.: 2010, 2012) and Stacey Langwick (See for ex.: 2008, 2011) to name but a few scholars. Thus, the epistemology of healing is a bulk of perceptions, ideas and interpretations related to health and treatment, which must be reproduced for the medical epistemology to exist and function properly.

Being a body of knowledge, epistemology is intrinsically fuzzy; due to this it allows for uncertainty. Indeed, trying to demarcate epistemology is an impossible task – we will inevitably face the fuzzy sets and categories. In this thesis I will argue that ambiguity is a core characteristic of the healing epistemology in Kigamboni. The lack of certainty was perceived as a natural state by most of my informants; the multiplicity of explanations was welcomed rather than dismissed.

Doing research, I was inspired by Robert Pool's approach which was aimed at 'gaining an understanding of people's ideas about illness [...] by placing them in a wider cultural context' (Pool, 1989: 20). In his study of the condition called '*kwashiorkor*' Pool showed 'how the meanings of key terms related to the illness [...] and to etiology more generally, are produced and negotiated in a praxis which includes anthropological fieldwork' (Ibid.: 21). Pool used *kwashiorkor* as a means of grasping the local healing epistemology. The importance of people's ideas about afflictions is quite explicit in Pool's research in India as well (cf. Pool, 1986, 1987a, 1987b). I incorporated the ideas of fuzziness and context-dependancy of misfortune(s) in this thesis.

Ria Reis (1994), who did her research of epilepsy in Swaziland, also argued that medical epistemologies should be studied in three dimensions: (a) patients' perceptions, (b) their practices in relation to afflictions, and (c) the social relations in which these patients are embedded. My research

⁴ In this thesis I will stick to this definition of the term 'epistemology'.

was aimed at studying all the three dimensions mentioned by Reis and is, thus, contributing to the literature on medical epistemologies.

The concept of borders

A number of scholars (among many Langwick, 2011; van Dijk, Reis & Spierenburg, 2000) have been using the concept of borders in order to analyze medical practices and epistemologies in Africa. According to this approach, healers cross both literal (geographical) and figurative (modern/traditional, urban/rural, material/epistemological, life/death, rich/poor, society/individual, moral/immoral, etc.) boundaries all the time, and that's what makes them powerful. But the healing power doesn't come from border-crossing alone; it's also about border-guarding. Thus, healers guard the border between the supernatural and material through appropriating the technique of divination. By doing this they ensure and protect their position as custodians and providers of certainty.

For the patients, on the other hand, the borders become fuzzier as modernity brings about new treatment options. With the abundance of choices, the borders disappear but it doesn't minimize uncertainty. Biomedicine trying to demarcate the boundaries between diseases and structure misfortunes symptomatically doesn't reduce uncertainty but simply claims the institutional power to control it. The difference between the doctors and the healers is in the approach; the former attempt to manage uncertainty by standardizing the experiences of individuals, while the latter opt for the exceptionality of every particular case. However, both the domains share one goal – to minimize ambiguity and fuzziness.

The goal of the borders concept is 'to discover how bounded entities are produced and reproduced in the practice of healing' (Luedke & West, 2006: 8). Still, the borders might not be perceived as such by the healers and their patients. A sick person does not necessarily distinguish the divide between different domains of medicine, but simply wants to be cured, be it by biomedicine or traditional medicine.

The concept of borders is relevant for this paper as I will analyze medical practices and ideas (and healing epistemologies in general) of the Kigamboni residents. This concept is closely intertwined with the notion of agency of the healer and the patient. They are both engaged in the shaping of interpretations of afflictions and, in a way, they are contributing to the medical epistemologies.

Efficacy and reciprocity

When it comes to getting treatment and handling uncertainty, the issue of efficacy becomes very important; I will use the idea of efficacy in this thesis, particularly in the fourth chapter. This concept

is useful for understanding the treatment decision making and the healing epistemology in general. Feierman (2008) argues that efficacy is largely dependent on the reciprocity between the healer and the client: in return for their services *waganga* demand money. In this case the money functions, on the one hand as the payment, and on the other hand as an instrument, that establishes the connection between the patient and the powers used by *mganga*. Without this reciprocity there is no treatment, as the efficacy is as guaranteed by reciprocal relations between the traditional healer and his client as much as it is ensured by the personality of the healer. As Feierman (2008) precisely puts it, 'money heals'. Efficacy influences the treatment choices of the patients and according to Feierman, dissolves the borders between biomedicine and traditional medicine as these two practices are becoming more and more interconnected: the monetary payment is no longer a privilege of biomedicine only.

Structure and agency debate

The structure and agency debate falls in line with the uncertainty rhetoric as it is aimed at understanding what choices people make when faced with misfortune and indeterminacy. This debate also explains the power relations between institutions (e.g. governments, NGOs, medical systems, structures, etc.) and individuals. This debate is relevant for me as I will argue that institutions play a crucial role in introducing the idea that *kifafa* is related to stigma and influence the healing epistemology in general. An attempt of biomedicine at reducing *kifafa* to 'clear' and 'transparent' epilepsy results in the further 'fuzzification' of *kifafa*. Despite these attempts, the residents of Kigamboni act as agents when it comes to making treatment choices and rely on their personal experiences rather than on strategies suggested by institutions (or structures).

The antagonism between agency and structure appears when we look at the limitations of freedom of an individual to make choices. Agency thus refers to the capacity of individuals to act independently:

In other words, the strength of a realization of agency should be recognized in the ways in which the individual would go about the constraints of such an inheritance system [structure], thus calling for a better understanding of the kind of reflexivity that allows a person, group or institution to take a different course of action (de Bruijn et al, 2007: 7).

Structure, on the contrary, refers to the recurrent patterned arrangements which influence or limit the choices and opportunities available (Barker, 2005: 448).

Though being within modernization paradigm, which assumes the 'makeability' of society and conceives structural patterns of economic, political and socio-cultural life, the idea of agency is in

contrast with that. If agency and reflexivity are individualistic and thus unpredictable, the whole idea of development loses its sense (de Bruijn et al, 2007: 7).

Theoretically developed by such scholars as Giddens, Archer, Ortner and Emibayer & Mische, the concept of agency questions early structuralism and structural functionalism (both approaches emphasize that behind social relations there is a structure and basically look at the society from a macro-level) (Ibid.: 3).

Agency has been conceptualized in academia very differently. For Ahearn agency 'refers to the socioculturally mediated capacity to act'; at that, 'all action is socioculturally mediated, both in its production and in its interpretation' (Ahearn, 2001: 112). I will use this definition of agency in my thesis.

Agency is often treated as synonymous to free will. Such scholars as Davidson (1980 [1971]: 43), Segal (1991: 3), Rovane (1998: 85) and some others identify agency with free will. The main weakness of this approach is that it 'ignores or only gives lip service to the social nature of agency and the pervasive influence of culture on human intentions, beliefs, and actions' (Ahearn, 2001: 114).

Feminist scholars (See for ex.: Andermahr, 1997, Davies, 1991, Dissanayake, 1996, Gardiner, 1995, Goddard, 2000, Kumar, 1994, McNay, 2000) are inclined to see agency as resistance. It's mostly been done to emphasize the seriousness of the female struggle against male dominance. Ahearn argues that 'oppositional agency is only one of many forms of agency' (Ahearn, 2001: 115). According to Ahearn, Foucault's approach (1977, 1978) leaves hardly any room for agency; 'his focus is more on pervasive discourses than on the actions of particular human beings' (Ahearn, 2001: 117).

Some scholars talk about 'vulnerable agency' of less-advantaged groups such as pregnant women, children and the sick (Ebrahim 1983; Morley 1973; Escobar at al. 1983; Wandel et al. 1984). They draw a very dark picture of the lives of these people; the emphasis is put only on the negative parts of the lives of those described as vulnerable. Indeed, poverty, famine, destitution and the pressure from people with more favorable conditions and from various institutions make the lives of these individuals hard. Yet, there is more to it, argues Rijk van Dijk (van Dijk, 2007). Vulnerability can be used by the disadvantaged groups as a tool of negotiating better conditions and access to resources, as it is done by some Ghanaian Pentecostal churches in Botswana:

By demonstrating their suffering and vulnerability, these churches argue their unity with the experience of the body social in the current predicament of Botswana society (Ibid.: 312).

In Tanzania on the contrary there was a period when the disavowal of vulnerability was highly politicized, promoted and even included into the ideological foreground of the ruling party.

Self-reliance as an answer to vulnerable agency

The policy of the Tanzanian ruling party CCM (Sw., 'Chama cha Mapinduzi' - Party of the Revolution) and its predecessor TANU (Tanganyika African National Union) was geared towards the so-called *Ujamaa* concept. Since 1967 when the Arusha Declaration was published and till the late 1980-s CCM was building its policy on the basis of African Socialism.

Self-reliance (Sw., '*kujitegemea*') as a concept was given much attention within the development (Sw., '*maendeleo*') discourse in Tanzania. The policy of self-reliance was 'aimed at providing the development for the country and its citizens, most importantly the poor' (Mapuri). Money was considered to be the outcome of development, not the source. That's why it was essential to stick to self-reliance and not ask for aid from abroad. Four things were said to be needed for *maendeleo*: *watu* (people), *ardhi* (land), *siasa safi* (good policy), and *uongozi bora* (good governance) (Ibid.).

The *Kujitegemea* policy was aimed at boosting agency of the Tanzanians vis-à-vis the European structure and at the same time organizing it according to the institutional and structural preferences of the Revolutionary Party. Recently, CCM has taken up a more neoliberal approach, but *kujitegemea* has become a life-credo for many Tanzanians, who are coping with difficulties and finding solutions every day. My respondents who had *kifafa* were very positive about *kujitegemea* and didn't represent themselves as disadvantaged and vulnerable. In fact, self-reliance is often used as a behavioral model by people suffering from afflictions.

Stigma

Stigma is the second major theoretical focus of the present thesis. Dwelling on my research of *kifafa*, I suggest that uncertainty around this affliction makes it less likely for a stigma to be produced. I will argue that *kifafa*-related stigma is a product of various institutions, which identify *kifafa* with the biomedical disease of epilepsy. As my data indicate the absence of stigma as well as the ambiguity and multiplicity of the interpretations of *kifafa*, I hypothesize that the production of stigma is related to a degree of certainty and clarity about misfortune. But before drawing conclusions it is needed to address the very concept of stigma.

The concept has been used by many scholars for many years, but debates about the best way of defining it are still very lively in the academia (Link & Phelan, 2001; Deacon, 2006; Reis & Meinardi, 2002). The fuzziness of the concept is intertwined with the uncertainty about where it can be applied

and where not. So what is stigma? First of all, it is a particular form of inequality. Inequality is usually understood as the uneven distribution of power, which is universal in any society, as witnessed by the fact that misfortune is selective, affecting some but not others (Nguyen & Peschard, 2003: 467). In this case disease (as well as affliction, misfortune and stigma) is also a form of inequality.

Thus, *kifafa* can be analyzed as a manifestation of inequality especially given that epilepsy is depicted as a stigmatized illness in the literature (Jilek-Aall, 2010; Winkler et al, 2012, 2010a, 2010b, 2009; Rwiza et al, 1993a, 1993b; Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001). Moreover, epidemiological research has shown that social inequality contributes to ill health independently of income level (See for ex.: Donohoe, 2003; Kawachi et al., 1999; Wilkinson, 1996). 'Gender inequalities operate simultaneously, but not identically, as systems of dominant meanings and symbolism; as structured social relations, roles, and practices; and as lived experiences of personal identity' (Mills, 2003: 42).

Stigma is as much a form of inequality as it is a product of power relations between individuals and institutions, which makes it better understood within the structure and agency debate. The concept of stigma is relevant for this thesis, as one of the main aims of the paper is to see if the perceptions of *kifafa* and the discourses introduced by various institutions contribute in any way to the stigmatization of this condition. In many cases scholars do not provide a comprehensible definition of stigma, refer to dictionary-like definitions ('a mark of disgrace') or use some related aspects like stereotyping or rejection (Link & Phelan, 2001: 364). Many scholars quote Goffman's definition of stigma as 'an attribute that is deeply discrediting' and that reduces the bearer 'from a whole and usual person to a tainted, discounted one' (Goffman, 1963: 3).

Stafford & Scott (1986: 80) propose that stigma 'is a characteristic of persons that is contrary to a norm of a social unit'. 'Norm' is a 'shared belief that a person ought to behave in a certain way at a certain time' (Ibid: 81). Crocker et al (1998: 505) argue that 'stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context'. Jones et al (1984) suggested a very influential definition, based on Goffman's (1963: 4) observation that stigma can be seen as a relationship between an 'attribute and a stereotype'. From their point of view, stigma is a 'mark' (attribute) that links a person to undesirable characteristics (stereotypes). Link & Phelan (See for ex.: Link & Phelan, 1999) added the component of discrimination to the Jones et al (1984) definition.

Link and Phelan stress that the term 'stigma' can only be applied 'when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold' (Link & Phelan, 2001: 367). If these factors are taken separately, it's

not correct to talk about stigma, though it's possible to research its components. So, in my thesis I will use the following definition of stigma: stigma is a 'mark' (attribute, label) that links a person to undesirable characteristics (stereotypes), which involves separation, status loss, and discrimination in a power situation that allows the components of stigma to unfold. This is the definition used by Link & Phelan (2001).

In a number of papers on HIV/AIDS-related stigma we read that 'stigma represents a construction of deviation from some ideal or expectation, whether the ideal is for "correct" sexual orientation or to be free of a disfiguring or fatal infectious disease' (Alonzo & Reynolds, 1995: 304). This interpretation of stigma is problematic as it doesn't explain how those deviations come about and how the ideals and norms are constructed. Moreover, the state of ill health is in itself a certain deviation from the ideal. According to this logic, every disease brings about stigma, which is of course not the case. Some health-related conditions can cause stigmatization while others can't.

The idea that stigma is constructed when a certain health condition deviates from the norm shouldn't be dismissed right away; yet, it needs clarification. If we agree with Alonzo & Reynolds and say that 'disease is essentially a deviation from what we expect or what we have been told to expect by medical authorities' (1995: 305), we'll conclude that it is the existing healing system (or epistemology) that defines which illnesses are stigmatizing and which are not. I will argue that for Kigamboni the idea about *kifafa*-related stigma is largely introduced by the pro-biomedical discourse. We have established that the norm is usually defined by certain authoritative institutions. But even in this case there must be reasoning behind those decisions, some kind of a scale measuring the amount of resentment towards particular illnesses.

Alonzo & Reynolds give the following reasons for HIV/AIDS being stigmatizing:

- Associated with deviant behavior, both as a product and as a producer of deviant behavior
- Viewed as the responsibility of the individual
- Tainted by a religious belief as to its immorality and/or thought to be contracted via a morally sanctionable behavior and therefore thought to represent a character blemish
- Perceived as contagious and threatening to community
- Associated with an undesirable and unaesthetic form of death
- Not well understood by the lay community and viewed negatively by health care providers (1995: 305).

Thus, such factors as contagiousness, the fear of death, obscure etiology, immorality and the level of social acceptability in terms of behavior are of grave importance for labeling a certain disease as

stigmatizing. Yet, I would argue that stigma is then very easily confused with discrimination, which can exist even when there is no stigmatization going on. Deacon (2006: 418) suggests 'limiting the definition of stigma to the process of othering, blaming and shaming (often called symbolic stigma)' and separating it analytically from discrimination. If we separate stigma from discrimination the former concept will lose its meaning as the definition given by Deacon is too broad to be productively used in the analysis; it also doesn't add any clarity to the process of stigmatization. In order to avoid confusion, I will support Link & Phelan's definition of stigma, which includes discrimination but only as a component.

Looking at agency and stigma I will be able to contribute to the understanding of the *kifafa* epistemologies. Epistemology being a system of knowledge about a particular sphere of life (in my case healing) can only be analyzed by looking at the way people choose their treatment (in other words, do they have agency?). The concept of stigma is relevant as it explains the stereotyping linked to some 'marks' imposed by the society, which involves a certain type of discrimination. Stereotypes are also parts of the epistemology of healing.

In the literature on epilepsy in Tanzania the concept of stigma is not addressed at all, while epilepsy is assumed to be stigmatizing everywhere (Jilek-Aall, 2010; Winkler et al, 2012, 2010a, 2010b, 2009; Rwiza et al, 1993a, 1993b; Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001). The article by Reis & Meinardi (2002) would be an exception here, but it doesn't focus on Tanzania specifically. Nevertheless, the authors acknowledge the need to address the concept of stigma (2002: 33), which they do in a thorough way. According to them, 'in the case of epilepsy, stigma refers to the extent to which people with epilepsy are separated from society on the basis of the meanings that are attached to the term "epilepsy"' (Ibid.: 34). I find this definition a bit vague and unclear: here stigma as a label of separation seems to be confused with stigmatization as a labeling process. Rather, these 'meanings that are attached to the term "epilepsy"' could be named 'stigma' (which would still be an insufficient definition) than the 'extent to which people with epilepsy are separated from society'.

Reis & Meinardi (Ibid.) also make a distinction between the two types of stigma: perceived stigma and enacted stigma. The former 'refers to the type of behavior a stigmatized person *expects* to encounter', while the latter 'denotes the *actual* behavior that is encountered' (Ibid.). Studies on epilepsy in Africa usually focus on enacted stigma, while perceived stigma gets more attention from Western scholars (Ibid.). In this thesis I will argue that people with *kifafa* in Kigamboni experience neither of these two stigma types.

I addressed a number of academic debates, approaches and concepts, many of which were rather ambiguous and demanded clear definitions. Now, that I have positioned myself within the scope of knowledge related to healing, it's time to go from theory to practice.

The Field and Methodology

De Bruijn & van Dijk (2012: 46) argue that ‘one can no longer think of the local without the global in Africa, and indeed many local realities are being shaped and reshaped in the view of new global connections’. Thus, geographically restricted location is no longer enough for research: ideas are travelling with people or through linking technologies of different nature. Research should be seen rather as space than as location. As Mirjam de Bruijn says⁵, one can study Africa from Europe using ICT (Information and Communications Technology). Inspired by this idea, I will define my field both as ‘place’ and as space of connections, which is influenced by ideas and discourses from elsewhere.

Kigamboni as location and space

I conducted my research in Kigamboni, which is an administrative ward in the Temeke district of the Dar es Salaam Region of Tanzania (See Map 1.). Located very close to Dar es Salaam, Kigamboni constitutes a border between urban (which is more influenced by biomedicine) and rural (which mostly depends on traditional medicine), for the settlement is larger than a village, yet smaller than a city. According to the latest census, the population of Kigamboni is 36,701 (Population and Housing Census General Report, 2002). The area is less densely populated than Dar es Salaam, has good beaches and is quite easy to reach by ferry, which makes it attractive for tourists and well-to-do Tanzanians.



Map 1. Kigamboni area (in yellow) and Dar es Salaam⁶

⁵ From private conversations and lectures given at Leiden University

⁶ All the maps are taken from Google Maps

Kigamboni is a place where various ideas about healing are exchanged and intertwined, which makes it a link between rural and urban, rich and poor, traditional and biomedical, etc. Many people from all over the country move to Kigamboni to benefit from tourism and bring their healing epistemologies along. Moreover, due to its proximity to Dar es Salaam, the area is very much connected to the global information flow and, thus, influenced to a certain extent by the biomedical discourse and development (Sw., 'maendeleo') agenda.

Practicalities

My research period was divided into two spans: the first one lasted for three months (from June 2012 till August 2012) and the second one took two months (from mid December 2012 till mid February 2013). The second span was mostly a follow-up research, so most data were gathered during the first period. For both research spans I arranged accommodation at the Russian-Tanzanian Cultural Centre (RTCC) in Dar es Salaam.



Map 2. My daily route to research location

RTCC is located relatively close to the Ferry Terminal (about four kilometers from it), so every morning I walked from my accommodation to the Terminal to take a ferry to Kigamboni. It took about forty minutes walking to get there and then about seven minutes sailing to get to my

destination (See Map 2.). Travelling around Kigamboni was also relatively easy and cheap: I usually took City Buses or the so-called *bajaji* (a tricycle that looks like an Indian rickshaw) to move around.

Most of my informants were based in the following settlements: Mjimwema, Kibugumo, and Kibada. This outcome was not planned beforehand; it just happened that most of the *kifafa* cases were found in these three villages. I also did a semi-structured questionnaire, which covered other villages of the Kigamboni area as well.

Methodology

As my research was aimed at grasping perceptions of *kifafa*, I decided to choose qualitative methodology with some quantitative elements. I was interested in the multiplicity of explanations and interpretations related to this condition; the quantitative method wouldn't allow for so many variations. Moreover, I didn't want to introduce any ideas of my own and tried to listen to people and their opinions. When I was doing my fieldwork I didn't use epilepsy as my starting point, the biomedically defined symptoms of this disease were not relevant for me when I looked for informants; when I was told that a certain person had *kifafa*, it was enough for me because I was interested in the scope of perceptions around this misfortune. I didn't come to Kigamboni with the ultimate truth about epilepsy; I came to get an insight on the way *kifafa* was represented in the explanations and interpretations (often fuzzy and ambiguous) of my informants. Thus, my goals defined my methodological choices.

The only technique I used that could be called partially quantitative was the semi-structured questionnaire. I call it semi-structured because the respondents were asked to express their ideas the way they wanted without ticking pre-supposed answers. Subsequently, I coded the answers and organized the survey participants in certain age, education, gender, etc. groups to see if their perceptions somehow correlated with these variables. My aim was to structurize the vast field of interpretations related to *kifafa* and to analyze what kind of people believed in what. That is why I needed to make use of this partly qualitative methodology.

Techniques and methods

In Table 1. I show which methods I used to answer the sub-questions. For each question I first determined the population that could provide relevant answers. According to the method, the population also varied. The largest research population was found under the (participant) observation method. I put 'participant' in brackets as it is difficult to assess to what extent I was able to actually participate in social events in Kigamboni. Bleek also finds the phrase 'somewhat presumptuous and misleading', as most researchers who use this method hardly participate in the

subject of their research (Bleek, 1987: 315). So, what I counted on realistically was observation. I tried to participate as well by teaching my informants how to read and write and by helping them with the household duties like cooking and washing the dishes.

In total, I got 105 surveys, 65 interviews of the Kigamboni residents (people not-affected by *kifafa*), 2 focus group discussions, 1 interview with a doctor from biomedical domain, 5 interviews of *waganga*, and 14 interviews of those having *kifafa* and *degedege* (See Chapters 2 and 3). The interviews of the people with *kifafa* and *degedege* were most often held in the presence of their caregivers; at times I could only interview the latter as many of the former had problems with hearing, speaking or were little children and couldn't be interviewed.

Methods Sub-questions	Open interview	Semi-structured interview	Extended case study	Focus group discussion	(Participant) observation	Semi-structured survey
1	X	X		X	X	X
2		X		X	X	X
3		X	X		X	X
4		X			X	

Table 1. Sub-questions and methods

1. What is the etiology of kifafa as perceived by people having it, their caregivers, neighbors, healing specialists and people who are not directly affected by this condition?

The population ascribed for this sub-question was very large – the Kigamboni community in general and people affected by *kifafa* in particular. I decided to start with the open interviews of randomly picked Kigamboni residents, as it seemed reasonable to first ask the people to reflect about various

health-related afflictions, *kifafa* among them. I just talked with people I came across while I was roaming around Kigamboni. **Open interviews** are also called unstructured, as they go on all the time and just about anywhere (Bernard, 2011: 156). Through these interviews I got an idea of the hierarchical position of *kifafa* (are there many people having it? how do people determine that it's *kifafa* and not any other condition? how dangerous is it? is it contagious, etc.) and some referrals to people with *kifafa*. I relied on the judgment of my informants as to who had *kifafa*; I didn't check the symptoms specifically also because it wasn't my goal, as I mentioned before. My assistant Johnny Shabani helped me to get to the homes (he showed me the way, as he was familiar with the location) of people with *kifafa* we were referred to. Open interviews were held with random people, though I tried to give more or less equal representation to women and men and to different generations. I interviewed at different places as well to make room for various local interpretations.

As I was establishing rapport through open interviews and the word of my research was spreading among the population, I decided to take the next step and ask people to fill in my **semi-structured survey** (See Appendix). The survey had thirteen questions, which I hoped wasn't too much to discourage my target population (Kigamboni residents who were not directly affected by *kifafa*⁷) from answering them. The questions were posed in English with the Swahili translation; some had answer variants, while many were open. Before asking people to fill the survey in, I would introduce myself as a Russian master student doing research on the opinions about *kifafa*. All the conversations were held by me in Swahili, which I had studied for five years in my alma mater, Moscow State University (MSU), so it was no problem at all to understand and be understood. Borchgrevink also stresses the importance of language skills for the researcher:

What difference does it really make whether the anthropologist knows a language well, less well, or not at all? The answer seems self-evident – the more you know of the language of the people you are studying, the better access you will have to information, the deeper understanding you will get, and the higher will be the overall quality of your fieldwork (Borchgrevink, 2003: 106-107).

At first people would assume I was a doctor, but I would say I was just a researcher. I would explain that I was not able to treat them and that I was just looking for interpretations of *kifafa* to subsequently write a thesis. Even after hearing that, they would still share their health problems with me, which I politely listened to and showed my empathy. Many respondents preferred that I would do the writing for them, as they were illiterate or just busy (e. g. cooking, doing laundry, working, etc.). After explaining the goals of my research, saying that it was for them to decide whether their real names could be used in my thesis and getting consent from the respondents, I would start with a

⁷ Here and further on I mean the residents of Kigamboni who didn't have *kifafa* themselves and who were not caregivers of a person with this condition

thorough explanation of the survey questions to make them as clear as possible. Then, I would pose the questions and encourage people to give detailed answers (by asking if there was something to be added). Some informants were more eager to cooperate with me than the others, so I asked additional questions to the people, who were willing to allocate more time for my work. Thus, what started as a questionnaire would turn into a semi-structured interview or even a group discussion. By the end of my first research span I got 105 surveys filled, put the data into Microsoft Excel 2010, and coded the answers.

In my research proposal I planned to arrange *focus group discussions* with different residents of Kigamboni, both directly affected by *kifafa* and not. Quite opposed to what I expected, I didn't have to organize any focus group discussions, they happened on the spot. The first one took place in Kibada, where I was interviewing one of my informants with *kifafa*. What started as a semi-structured interview soon became a discussion when the neighbors, the mother and the preapostor joined in with their comments and explanations. Every person who took part in the discussions started the participation with a greeting, after which (s)he was explained what we were talking about; that's how I could keep track of the discussants. The second focus group discussion took place in Mjimwema when I was interviewing and getting the surveys filled in. This time people involved in the discussion were not directly affected by *kifafa*. The discussion started with me interviewing a young mother, whose house was located very close to the mosque (*Msikiti wa Jangwani*). Numerous passers-by got curious of me and my research, so many would stop, linger and contribute to the discussion.

Finch & Lewis (2003: 172) define the focus group discussion as a process which 'reflects the social constructions - normative influences, collective as well as individual self-identity shared meanings - that are an important part of the way in which we perceive, experience and understand the world around us'. Indeed, watching the participants argue, comment on each other's opinions, agree and disagree with each other gave me a chance to get data through the interaction I witnessed (Morgan, 1988: 12). As the setting was very natural (Kreuger & Casey, 2000: 11) and I barely participated in the discussions, I indeed felt that the role of researcher was being taken from me by the members of the focus group discussion (Finch & Lewis, 2003: 171). However, I agree with Finch & Lewis that the information given by every participant is not very detailed (Ibid.). Focus-group discussions were very useful in terms of getting general information, which I used for generating more context-related questions in the course of semi-structured interviews. Yet, my impression was that I learned more from interviewing face-to-face and in-depth than from the focus group discussions.

I conducted **semi-structured interviews** with people who had *kifafa*, their caregivers and neighbors, people not affected by *kifafa*, and various healing specialists. As I mentioned before, many people who participated in the survey were also willing to elaborate on their answers, so I interviewed them in a more thorough way. I must stress again, that in my research I was dependent on the way the residents of Kigamboni determined who had *kifafa* and who didn't. I never questioned their judgment also due to my non-medical background, but most importantly because my goal was to understand the local interpretations of *kifafa* and try to look at this condition from the people's perspective. However, symptomatically *kifafa* was described as a condition similar to biomedical epilepsy by all the respondents.

In order to interview *waganga*, I had to be referred to them, as well as to the people with *kifafa*. In this matter I relied on my research assistant Shabani, who took me to all the healers I interviewed. In the course of my research I never paid my informants, but *waganga* were an exception: they all demanded money for letting me interview them⁸. We agreed on a reasonable sum, so I paid them. My interview guide was as follows: 1. Do you know the symptoms of *kifafa*? 2. Can you treat it? 3. If yes, what do you treat it with and how? 4. How much do you ask for the treatment? 5. Do you have success cases when people completely recovered? 6. Do you treat every *kifafa* case the same way? 7. What are the causes of *kifafa*?

(Participant) observation is indeed 'the foundation of cultural anthropology' (Bernard, 2011: 256). It can be described as 'experiencing the lives of the people you study as much as you can' (Ibid.: 258). The most important aspect of it in my case was cross-checking the data I got from other research techniques and seeing if the practice correlated with what I was told by the informants. I soon found that there was no secrecy about *kifafa*, so basically the value of (participant) observation was to confirm that this affliction was not stigmatizing: *kifafa* was part of everyday life. Participating in the lives of the families that took care of a person with *kifafa* was more beneficial than witnessing the seizures themselves. I got rapport and was allowed to probe deeper into the personal and even intimate details of the lives of my informants. Thus, this method was not crucial but nevertheless very useful for my research.

2) How do people shape the treatment of kifafa and how is the treatment method negotiated (if it is) in the course of treatment?

The second sub-question was mostly aimed at the people who had *kifafa* but also at residents of Kigamboni in general, who were asked to imagine what they would do if they or their family

⁸ As I explained in the Theoretical Framework (pp. 20-21), asking money for a consultation is a cultural practice related to efficacy and reciprocity.

members had this condition. I used semi-structured interviews with people who had *kifafa*, their caregivers and neighbors, and people who were not directly affected by *kifafa*. Semi-structured survey, (participant) observation and focus group discussion were also applied as my research techniques to find the answer to the second sub-question. My interview guide was aimed at understanding what type of treatment was preferred by the residents of Kigamboni and how much it depended on the perceptions and ideas about the etiology of *kifafa*. In case of the people with *kifafa* themselves, I was wondering if the treatment was constantly negotiated and changed in accordance with its efficacy.

3) Do perceptions of kifafa contribute in any way to the stigmatization of this condition? To what extent is the kifafa-related stigma (if it exists) a product of various healing domains?

The third sub-question was the one that I struggled with the most. It was partly due to the relative vagueness of the whole stigma concept (which I, though, tried to overcome to some extent in the **Theoretical Framework** of this thesis), partly to the authority of my academic ‘predecessors’ who researched epilepsy in Tanzania and concluded that stigma was indeed there (Jilek-Aall, 2010; Winkler et al, 2012, 2010 (a), 2010 (b), 2009; Rwiza et al, 1993 (a), 1993 (b); Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001).

When I entered my field I was determined to be impartial and not to show my attitude towards stigma at all. In fact, the very word ‘stigma’ was never used by me in the course of research. My goal was to see if the aspects of stigma like discrimination, status loss, labeling, etc. were experienced by people with *kifafa*. I was also interested in seeing how the residents of Kigamboni reacted to people with *kifafa* and the condition itself. For that I used semi-structured interviews both with people with *kifafa* and the not-affected people.

My questions were very practice-oriented: I didn’t ask if people with *kifafa* were discriminated against, labeled, excluded or stigmatized; but I did ask if they felt like they were just as any other resident of Kigamboni, if they had shame because of their condition, if they had friends, if they had a job, if they were helped by the neighbors, if they kept their condition secret, etc. I asked similar questions to people without *kifafa*, who were asked to reflect upon how people with *kifafa* felt and what they thought about people with this condition (would they be friends with them, marry them, work with them, help them, etc.). The perceptions about contagiousness of *kifafa* were also crucial for understanding *kifafa* stigmatization, which, I argue, was absent in Kigamboni. The semi-structured survey I used gave me an insight on how the perceived contagiousness of *kifafa* was related to the attitude towards people with *kifafa* and its perceived causes. As always, I used

(participant) observation to check how/if the practice of life differs from the answers I got using other research techniques.

As advised by Bernard (2011: 158), I used an interview guide for discussing more personal and sensitive topics than in open interview, where the conversation goes on its own without researcher 'leading' it. The guide for people with *kifafa* included the following questions: 1. Do you feel that you are treated exactly as any other resident of Kigamboni? 2. Do you have friends? 3. Does everyone know about your condition? 4. If yes, do people help you when you have a seizure? 5. Is it hard to find a job with your condition? 6. Is it hard to find a life partner? 7. Are you ashamed of your condition? For the interviews with people who were not directly affected by *kifafa* I used the following guide: 1. What do you think about people who have *kifafa*? 2. Would you be ashamed if you or one of your relatives had *kifafa*? Why? What would you do (if anything) to treat it? 3. Would you marry someone with *kifafa*? 4. Do you think that *kifafa* is contagious? If so how can one get it? 5. Would you help a person with *kifafa* during a seizure? 6. What do people normally do when they see someone who has *kifafa* having a seizure?

To probe deeper into the third sub-question, I applied the ***extended case study*** method. It was developed as a method by the Rhodes-Livingstone School, also known as Manchester school. The method is about focusing on what is happening in the field and getting insights about structuring elements of social practices. Such scholars as Gluckman (cf.: 1941, 1951, 1954), Lee (1990) and Mitchell (1956) used social events as entry-points allowing them to analyze societies. I used this method to analyze the behavior of people in a certain situation, in my case I wanted to know how people would react if they saw a person with *kifafa* having a seizure in a public place. Indeed, I witnessed one of my informants having a seizure. Thus, the extended case study method helped me to double-check the data I gathered through interviewing.

4) Do the interpretations of kifafa (in both public and domestic domains) differ between various gender/age/education, etc. groups?

The fourth sub-question is very analytical, as it relates to the gender debate and requires the data analysis to be answered. I used the semi-structured survey, interviews and (participant) observation for answering this question. The interviews were conducted with people who had *kifafa* alone, as the question goes about their personal experiences. The fourth sub-question a great deal relies on the data gathered from answering the other three sub-questions.

Under the category of gender I divide the population into two groups: males and females. The category of age has five variables: group 1 (15-<=25 years of age, the youth); group 2 (26-<=35, the young); group 3 (36-<=45, the middle-aged); group 4 (46-<=55; the aging); group 5 (>=56, the

elderly). The respondents are also distributed in groups according to the level of their education: group 1 (people with no education); group 2 (primary school); group 3 (secondary school); group 4 (university degree).

Ethical concerns

Ethics remain a matter of choice despite its universality claims. Yet, the data we collect are influenced by the ethical standards we apply in the field. Negotiating consent is considered to be very important in many ethics codes. The Australian Anthropological Society Code of Ethics (the AAS code) describes consent as ‘a process’ and ‘issue to which anthropologist should return periodically’ (AAS Code of Ethics, 2003: 3.4 (c)). Before going to Tanzania I familiarized myself with the AAS code and the AAA (American Anthropological Association) Code of Ethics and tried to follow their guidelines.

In the course of the interviews everyone was allowed to refuse answering any question or to end the interviewing session at any moment. I didn’t use any voice/video recorders and only took notes. In the course of my research I always asked permission to interview my informants, take pictures of them and use their real names. Nevertheless, I had some doubts about using all this information in the thesis, but then I realized that if I didn’t use it I’d be arguing against my own argument, which emphasizes the plurality of interpretations and acceptability of *kifafa* as well as denies the existence of any stigma and discrimination related to this condition. Also when I saw that biomedical facilities provided people with *kifafa* with special ids with personal information on them, which was available to everyone (see Chapter 5), I was convinced to discard any doubt about using the information of this kind in the thesis.

Being over-cautious would not only ruin my argument, it would also oppose the very healing epistemology of Kigamboni, which denies secrecy in the case of *kifafa*. The people having this condition (or conditions) I interviewed and spent months with wanted to be seen and heard; they had no shame and no doubts about it. Thus, drawing from my fieldwork and personal integration within the local community as well as the wishes of my informants, I decided to use the pictures and the real names⁹ in my thesis. If I claim to grasp even a tiny piece of reality I must be willing to write about *kifafa* openly, with real names and the real people behind my argument. This is a way of making my point firm and valid.

⁹ To be more precise, I am not sure that the names I was given were real. They could’ve been just nicknames as it is a widespread practice in Tanzania. Moreover, I never asked for the real names, I always stressed that this was optional and explained that I needed some names just to avoid confusing my informants with one another.

Chapter 1. Ambiguities of *uganga*

Healing hasn't always been the same in Tanzania as much as it hasn't been elsewhere. Though we might not be able to track all the changes, we still can try to grasp the general tendencies of the healing evolution. It's important to address *uganga* (Sw., 'healing') in all its ambiguity and indeterminacy in order to understand how the perceptions about the etiology of afflictions influence the treatment people choose. Thus, this chapter is closely connected to the following chapters related to the causes of *kifafa* and subsequently treatment decision-making.

I will give a brief history of *uganga* (Sw., 'healing') and its relation to witchcraft in Tanzania. I will also describe the current status of *uchawi* (Sw., 'witchcraft') and *uganga*, the position of the Tanzanian government towards them and show that the discursive uncertainty about *kifafa* has its roots in the past. The aim of this chapter is to show that the uncertainties around *kifafa* stem from the ambiguities of *uganga* and its 'evil' doppelganger *uchawi*. The reader will find that the governments and international institutions have been playing a crucial role in standardizing the healing in Tanzania and, thus, introducing biomedical ideas, etiologies and interpretations, the idea of stigma being among them. As for the healers, they find the uncertainty of *uganga* (and, as we will see later, of *kifafa*) to be a comfortable space where they are custodians of certainty. Through the divination and the individual approach to every patient they minimize the uncertainty for every particular client, while keeping the misfortune itself fuzzy.

The Tanzanian Government is trying to organize and control the healing domain and to promote specific treatment types along with popularizing its own healing epistemology. There have been a number of attempts at structuralizing and legalizing *uganga*; yet, it is not an easy task given that *uganga* exists in the field of ambiguities and these multiple uncertainties in fact make it work. The role and status of *uganga* have been changing over the centuries. Therefore it is useful to look at the dynamics in its perceptions for a more profound understanding of its present status.

The history of *uganga* is very hard to track as it goes back far beyond the establishment of the Western contacts with Africa. We also do not possess the indigenous written sources, which could allow for discovering the position of healing in the East-African region. As an institution it combined religion, sorcery, witchcraft (Sw., '*uchawi*'), health and interpersonal conflict in one single form of cultural belief and practice (Katz & Kimani, 1982: 170-174). Before the arrival of missionaries and the colonial conquest in the late 19th century *waganga* and the political leaders allied with them controlled the matters of health and magic. Handling conflicts between community members among

other things, they possessed considerable political power and enjoyed high social standing (Erdtsieck, 2003: 29).

Migrations and tribal wars in Tanzania

The population of Tanzania is composed of various ethnic groups but the majority of them are Bantu. It is believed that the Bantu came to East Africa from the South-Eastern Congo Forest before 1000 A. D. in search of fertile soils, and settled in Tanzania between 1000 and 1500 (See for ex.: Okello Ayot, 1976 or Tindall, 1985). After the four migration movements the Bantu settled in central and northern Tanzania, in coastal and highland areas and in the south. The non-Bantu speaking people of Tanzania mostly originate from the Horn of Africa, Ethiopia, Sudan and the Nile Valley (the Nilotics and the Cushites). The Hottentots, Bushmen and Pygmies originally came from Central and East Africa (Erdtsieck, 2003: 31).

The Ngoni invasion and caravan trade

The last Bantu group to arrive in East Africa was the Ngoni (Nguni). They were seeking refuge from the warfare in South-East Africa and occupied the Ufipa Plateau in Tanzania by 1840 (Brock, 1966; Knight, 1974; Ebner, 1987). Later on the Ngoni groups split: some of them went south to Malawi or the Congo, others raided the north up to Lake Victoria. There they encountered the Nyamwezi, whom they attacked and defeated. Eventually, faced by the strong Hehe, the Ngoni were driven off.

The arrival of the Ngoni brought drastic changes both to social and economic lives of the people in East Africa. The expansion disrupted the daily routines and trade, which resulted in the formation of military states to stop the Ngoni. The war between the united Hehe clans and the Ngoni lasted until the German occupation brought it to a halt in 1885. War medicine (*amahomelo*) was largely used by both the rival groups to empower the warriors. The tactics and medical knowledge were often copied from the Ngoni. The Germans ended the war between the two tribes by occupying the Ngoni territories. The Hehe yet fiercely resented the newcomers, and the Germans only managed to subdue their resistance in 1898 (Okello Ayot, 1976: 159-165).

Ngoni diviners were known to be in contact with the spirits of ancestors. They were rainmakers, specialists in treating illnesses, interpreters of omens and dreams. Their social standing was quite high: the best diviners were called by the paramount chiefs in times of crisis (Read, 1970: 179). Pre-colonial healing took place in alliance with chiefs and elders, but local healers also influenced health matters and environmental and geographical issues like selection of village sites and health quarantines (Feierman, 1986: 208).

In the early 1850s already large caravans of porters or *wapagazi* were transporting ivory, slaves, cloth and other goods from the inland to *pwani* (the coast). Due to the dangers of the long road the help of *waganga* was needed for the safety and protection. Important diviners were sometimes also ivory merchants, and besides performing their direct duties organized their own caravans (Speke, 1864: 125). *Waganga* protected the people of the caravan and ritually cared for the ivory: the tusks were marked with spots, lines and figures, which ensured the safe arrival to the destination. They usually carried only a light load 'in view of their calling' (Burton, 1860: 241). Burton mentions that for the caravan leader it was essential to purchase 'charms and prophylactics' from his diviner (Ibid.: 112). He also had to wear the 'medicine for the road, strapped around his waist' (Ibid.: 240).

As Stephen Rockel argues, commodification of caravan labor was followed by the gradual spread of market relations along the central routes (Rockel, 2000: 186). *Waganga* travelled huge distances and for sure encountered their local counterparts. There must have been exchange of knowledge going on as well as the commodification of the services provided by the diviners. Thus, the foundation for the contemporary healing was laid in the 19th century.

Uganga was very much perceived as opposed to witchcraft, which it was constantly fighting. Roughly speaking, *uganga* was the healing practice quite similar to *uchawi*. The difference was mostly about the client and the morality of the two: the former was largely reacting to the malevolence produced by *uchawi* and thus protecting; the latter was highly aggressive and aimed at doing harm. Thus, the main difference between the two was in the client. If the client was harmed he would go to a healer to look for *uganga*; if the client wanted to harm he would go to a witch to look for *uchawi*. *Uchawi* was (and still is) referred to practices of malice coming from persons by means of sorcery or witchcraft. In pre-colonial times *wachawi* (sorcerers) were controlled by the institute of *waganga* and the ordeals. So, *waganga* were making sure that the balance between the harmful witches and their victims was intact. Thus, *uganga* and *uchawi* were closely interconnected (See for ex.: Pels, 1999).

In order to see how the image of Africa (and *uganga* in particular) was created by the famous travelers such as Livingstone, it is useful to address the article by Tim Barringer (1996). The Victorian attitude towards Africans was expressed through binary oppositions: civilized/savage, clothed/naked, Christian/heathen, light/dark, white/black (Barringer, 1996: 172). In the colonial times first the Germans and then the British will perceive Africa on the basis of this image.

The colonial period

When the Anglo-German Agreement was signed in 1889, Germany was given the area to the east from Lake Tanganyika, which soon became its protectorate. The German administration saw a threat in the politically influential healers and initiated prosecutions, leading to the killing of various *waganga* (Feierman, 1986: 207-208).

The diviners played a big role in the Maji Maji revolt of 1905-1907, led by a Hehe chief. A rumor was being spread that some medicine man, taking the form of a monster and living in the waters (Sw., 'maji') of the Rufiji River, dispensed a medicine which ensured protection against disease, famine, bullets and malevolent forces in general among the rebels. The Germans proved the rumors untrue by suppressing the uprising brutally (Erdtsieck, 2003: 39). In 1909 the German administration appointed district officers to regulate *waganga* by issuing certificates specifying the conditions that were treated, the prices charged, and the practice location (Ibid.).

A harsh punishment instated by the colonial government for the people accused of *uchawi* and for those who administered poison ordeals to detect witches was followed by a number of witchcraft eradication movements, which came about in response to the German legislation, according to Iliffe (1979). Langwick argues that 'rather than identifying those doing harm, eradication movements protected all of the potential victims' (Langwick, 2011: 45). Eradication experts claimed that they could protect the whole population against witches; they distributed medicines among the people with a warning that those who were practicing *uchawi* would die after taking them. Colonial officials were concerned about the popularity of these movements and the mobilizing power of their leaders. The memory of Maji Maji was still fresh and the witchcraft eradication movements were seen as political enemies, which compromised the success of colonial government. Medicine's role as the evil eliminating tool was overlooked, which resulted in confusion around *uchawi* (Ibid.: 46). The attempts at putting witchcraft under control were taken over by the British after World War I, when Germany was defeated and lost its African territories.

The concerns of the British administrators about witchcraft in Tanganyika were to a large extent induced by the fear of the Maji Maji rebellion, which itself serves as an instance of the political and social power of medicine (Langwick, 2011: 43). Yet, the witchcraft eradication movements were also of great concern for the British governance: they distributed the first witchcraft-related circulars in 1919 already (Ranger, 1966: 6). 'Witchcraft' was defined as a legal offense against the colonial government in order to prevent any possible attempt of another Maji Maji rebellion (Ibid.: 46). Thus, it was needed to classify the existing medical practices according to their potential threat to the administration and define which of them could be considered useful or even benign. It must be

mentioned, though, that the British didn't see all the witchcraft eradication campaigns as threatening. In fact, they were very flexible in their policies, sometimes even fostering such movements in hope to limit the agitation about *uchawi* among the 'credulous natives' (Ibid.: 47).

The authorities issued the Witchcraft Ordinance in 1922 (cf. Mesaki, 2009), which made it illegal to practice *uganga* with the intent to use or counter-act witchcraft. Virtually all forms of indigenous practices in *uganga* but rainmaking¹⁰ were rejected as encompassing sorcery (Erdsieck, 2003: 40). As the British didn't believe in *uchawi*, they proclaimed its very existence impossible, also legally: 'witchcraft emerged in British law as the manipulation of individuals and groups through purported and false claims to access to "occult powers"' (Langwick, 2011: 51).

The 1928 revision of the Witchcraft Ordinance is still in effect in Tanzania. The prohibitions against divination and the practice of distributing medicine to whole communities made the efforts of the colonial administration to separate *uchawi* from *uganga* explicit. The legislation was built upon the European understandings of what magic and medicine were. *Uchawi* was defined as 'an antithesis of modernity: a production of illusion and delusion that was thought to recede and disappear as rationalization and secularization spread throughout society' (Pels, 2003: 4). Thus, *uchawi* was classified as 'black art' while *uganga* (its herbalist part to be more specific) as 'scientific' or rather 'pre-scientific' (Langwick, 2011: 50). The Swahili word '*uganga*' that used to define healing in general was applied by the colonial administration as the term for herbalism.

Stacey Langwick argues that 'colonialism transformed what and who had the right to exist in Africa':

In colonial Tanganyika, revisions of the witchcraft ordinance and companion policies concerning native medicine divided African therapeutics into practices to be disciplined by law and those to be disciplined by science. These legal statutes cast witchcraft as fraud and witches (as well as the healers that combated them) as charlatans, while leaving open the possibility that herbalism was a proto-science and that herbalists were custodians of knowledge obtained over the centuries by trial and error. These attempts to separate African therapeutics into witchcraft and herbalism generated the forms of skepticism and kinds of evidence that continue to shape debates about traditional medicine in Africa today (Langwick, 2011: 39-40).

Colonial struggle against witchcraft affected both *wachawi* and *waganga*, as the British administration didn't distinguish between the two groups. At the same time, herbalist *waganga* were seen as potential allies because their practices were more understandable and could be incorporated into the biomedical domain of healing (Ibid.: 40).

¹⁰ On the present-day practices of rainmaking see for example Sanders (2000; 2002; 2003)

The non-cooperation of the British in the fight against witches raised suspicion about the authorities, which seemed to defend *wachawi* (Pels, 1999: 245). By the 1930s the interest to indigenous medical practices on the part of the government urged Lord Hailey, an expert on 'native affairs' to register traditional healers. That was thought to help incorporating *uganga* into modern medicine (cf. Mesaki, 1998). Hailey's survey showed that not all *waganga* were involved in *uchawi*. The Medical Practitioners and Dentists ordinance was much more tolerant to *uganga* than the previous ones:

Nothing contained in this ordinance shall be construed to prohibit, or prevent the practice of systems of therapeutics, according to native methods by persons recognized in the community to which they belong and who are duly trained in such practice (Swantz, 1990: 12).

The British didn't interfere with the development of *uganga* unless the practices lead to murder. The healing became less concerned with 'fixing' communities, it shifted from social practice to individual. Pels argues that the individualization of treatment and the shift from spirits to herbal medicines was a 'symptom of the decreasing power of the lineage in day-to-day affairs' (Pels, 1999: 246). Thus, colonial legislation mostly benefited the lowest hierarchical branch of *uganga* – herbalism. By trying to discern and codify witchcraft the authorities were producing new meanings and changing the notions of *uganga* and *uchawi*. The process of standardizing and institutionalizing the healing was under way.

Intstitutional development

Nyerere's Tanzania

In the years following the independence (1961) the TANU (Tanganyika African National Union) party lead by Julius Nyerere came into power. Despite ideological opposition to the British colonialism the new government found itself facing the same health-related problems. The heritage of the colonialists manifested in the form of ontological implications originating from the 'colonial separation of belief and knowledge, spirit and substance, and harming and healing' (Langwick, 2011: 58). Nyerere's administration was geared towards supporting herbalism, commodification of plant, animal and mineral substances, which were to be converted into valuable pharmaceuticals. Substantial funds were allocated for research into medical plants in hope of creating domestic pharmaceutical industry and tackling numerous healthcare problems. This policy was very much falling in line with the political agenda of that time and the *Kujitegemea* (self-reliance) concept in particular.

As a country committed to socialism and the non-aligned movement, Tanzania was looking for medical models that could be appropriated by the country; Tanzanian officials studied medical

systems of socialist countries and got inspired by them. Chinese healthcare policy was found particularly inspiring as it was attempting to combine traditional and modern medicine in one medical system (Langwick, 2011: 59). This model was also appealing for the new government of Tanzania because it didn't require lavish investment in healthcare: Chinese 'barefoot doctors' were minimally trained and could reach a large rural population. The sympathy towards China's model was also due to a number of Tanzanian officials, who studied biomedicine in China. One particular example is Sabina Mnaliwa, who devoted herself to the formal legalization of traditional medicine in Tanzania (Ibid.: 60).

In the 1960s the health situation in Tanzania was in bad state, according to Mesaki (1998). In the mid 1970s within the *Ujamaa* villagization policy (cf. Scott, 1998) an attempt at supplying the demand in modern trained health staff was made: 6000 village health workers were trained to provide basic healthcare and modern medicines for rural communities (Erdsieck, 2003: 41). The progress of biomedicine in Tanzania hasn't been overwhelming, yet it was there. Modern medicine didn't eliminate *uganga*, rather it got incorporated by it as a part of the healing process.

In the late 1970s the World Health Organization was focused on the importance of integrating traditional medicine into African healing systems. Tanzania showed its commitment to the WHO ideas by hosting the Executive Committee of OAU's (the Organization of African Unity) Inter-African Committee on Medicinal Plants and Pharmacopoeias in Dar es Salaam. These efforts were followed by the joined research of traditional medicine, which involved international collaboration (e. g. the documentation of all the literature on traditional medicine since 1900, which was available in East-African libraries). The deputy director-general of the WHO, Professor T. A. Lambo, even promised to finance further traditional medicine research during his visit to Dar es Salaam and expressed his appreciation for Tanzania's commitment to the development of traditional healing practices (Langwick, 2011: 64).

Later on The WHO and the United Nations included traditional medicine into the development rhetoric: in 1978 the United Nations Industrial Development Organization (UNIDO) held its first international meeting devoted to technical aspects of plant-based pharmaceutical production (Ibid.). A month later a WHO-UNICEF conference in Alma Ata about primary healthcare stressed the importance of the incorporation of traditional practices into the medical systems of the developing countries. By 1980 the World Bank had begun encouraging investment into the efficacy and availability of traditional medicine. Thus, traditional medicine was recognized as a resource for development by a number of official institutions including The Tanzanian Ministry of Health, Dar es

Salaam University, The Organization of African Unity, the UN, and the World Health Organization (Ibid.: 65).

In 1974 a Traditional Medicine Research Unit was established in Tanzania, which was later elevated to the Institute of Traditional Medicine in 1991. The main goal of the Institute was and still is to study traditional healing systems and practices in Tanzania and to identify *materia medica*, which can be 'modernized' and developed into drugs (MUHAS, 2012). The objectives of the Institute are as follows:

- To promote the use of traditional medicines and traditional methods of healing
- To promote commercial exploitation and conservation of medical plants
- To contribute to the discovery of new drugs
- To contribute to the local production of pharmaceuticals
- To disseminate knowledge on traditional and plant derived medicines (Ibid.).

The growing acceptance of *materia medica* was further supported by the opening of the Institute of Traditional Medicine at Muhimbili in 1981 (Langwick, 2011: 65). Yet, this acceptance wasn't always unanimous and unconditional; in late 1978 the minister of health, Dr. Leader Stirling, accused traditional healers of facilitating the spread of cholera during an outbreak by giving people protective medicines, which led them to neglect the necessary precautions. Subsequently, a large traditional medicine clinic was investigated and then demanded to comply with the health department's sanitary regulations. This incident led the Tanzanian Ministry of Health to realize that traditional medicine could cause quite unfavorable health situations if not controlled by the administrative system. The ambiguity of seeing traditional healing as 'pre-science', which could be exploited and researched, and at the same time looking at certain aspects of the traditional practices as dangerous and harmful, resulted in the need to reconsider the relationship between healers and the health ministry. In July 1981 Minister of Health Ndugu Aaron Chiduo ordered to draft a constitution of a newly established registered organization of healers. The constitution was to be written in cooperation with *waganga* (Ibid.: 66).

Despite visible equality of this cooperation, it was in reality an attempt of the government to discipline traditional medicine and prevent it from becoming the ends when it was intended for it to be the means. For instance, in November 1981 the Ministry of Health condemned a newly established traditional drug company Madawa ya Asili Company Limited, saying that it was illegal to commercialize traditional drugs. The herbalist part of traditional medicine was usurped by the Tanzanian administration; the healers' attempts to capitalize their herbal remedies and transform

them into commodities were cracked down by the government. Traditional healing was supposed to stay under control as a development resource and healers themselves were viewed not as independent agents of this development but as obedient contributors (Ibid.).

Capitalist Tanzania

Several studies showed that people in East Africa were not happy with modern healthcare in the early 1980s (Katz & Kimani, 1982; Ojanuga, 1981; Leshari, 1984). The most common reasons for dissatisfaction were (Erdsieck, 2003: 43-44):

- Hospitals are too far away in case of urgent treatment.
- Long waiting time in urban hospitals or rural clinics.
- Short appointments with doctors or hospital staff.
- Feelings of confusion and being alone in an unfamiliar environment.
- Having little opportunity to express one's own concerns and fears.
- Little or no concern for psycho-social context of disease.
- Misunderstandings between medical staff and patients about disease concepts.

Due to the above-mentioned reasons millions of Tanzanians used the services of *waganga* (and continue doing so today). That meant that the indigenous practices needed to be judged for their merits, since modern medicine couldn't sufficiently compete with the incidences of illness in Africa (Ibid.).

Already in 1970s the economic situation in Tanzania was far from good: oil crisis, droughts, corruption, and the war with Uganda against Idi Amin plunged the country into debt. The International Monetary Fund (IMF) demanded structural reforms, emphasizing 'that the role of government was to create a good business climate rather than look to the needs and well-being of the population at large' (Harvey, 2005: 48). Under pressure, Nyerere tried to maintain his obligations to the basic needs of the citizens while addressing the business problems as well: in the 1980s he introduced some Tanzanian-style structural reforms. But these efforts were in vain; the IMF and the World Bank refused loans to Tanzania until *Mwalimu* (Sw., 'teacher'; this is how Julius Nyerere was called by Tanzanians) resigned in 1985. After Ali Hassan Mwinyi became president Tanzania surrendered and adopted the structural adjustment programs. The era of *Mzee Ruhsa* (Sw., literally 'old man permission'; translated into English as 'everything goes') was characterized by the

liberalization of the economy, floating currency, privatization of industries, and cuts in social services including healthcare (Langwick, 2011: 68).

Thus, since the mid 1980s Tanzania has been influenced by the neo-liberal ideas of the economic *laissez-faire*, commoditization of the traditional medicine and 'letting the market do its job'. The structural adjustment reforms encouraged by the World Bank in the 1990s made Tanzania very attractive for various international funds and development organizations. The HIV/AIDS pandemic made various NGOs and the Tanzanian government join hands in doing research on *materia medica*, which could be used to treat this condition (Ibid.: 71-72). New notions of modernity promoted through market liberalization drove changes in both *uchawi* and anti-witchcraft. Today the fears of sorcerers are becoming more explicit; various newspapers report the cases of albinos being attacked to obtain 'medicinal' body parts from them (See for ex.: BBC News, 2012, 2008; The Guardian, 2008). This might be the reaction of the people to the further commodification of *uganga* and its shrinking to herbalism.

Traditional healers are under pressure from the government and international development schemes auspices to organize into a national association and be trained as outreach workers and birth attendants (Langwick, 2011: 16). In 1994 the ministry of Health requested *waganga* and *wakunga* (midwives) to form The National Organization of Traditional Healers and Midwives in Tanzania (*Chama cha Waganga na Wakunga wa Tiba ya Asili Tanzania – CHAWATIATA*). About 50% (at best) of the traditional practitioners are members of CHAWATIATA, which makes their services legal. Yet, many diviners don't pay the membership fee and don't have the permit to treat patients. Besides that, the association itself is a very loose body comprising *waganga* and *wakunga* of different gender, origin and clientele. Urban healers, for example, are mostly herbalists, while their rural colleagues rely largely on divination. Thus, instability, division and difficulties prevent CHAWATIATA from being efficient. It will take some time before it can truly represent the interests of the various healers and the needs of the public (Erdtsieck, 2003: 51).

Waganga themselves didn't appreciate the efforts of the NGOs and their own government to put them under control and recognize the superiority of biomedicine. That would have meant the loss of their high social position and respect of the clients. Already in 1978 *uganga* was placed under the authority of the Ministry of Arts, Education and Culture in Tanzania. Diviners throughout the country were provided with official permits, which allowed them to practice under the legislation used by the British. Even before that there were attempts at creating an association of healers, but it was difficult due to the lack of leadership (Erdtsieck, 2003: 45).

Tanzanian officials are still inspired by the Chinese model, where traditional medicines are manufactured as pharmaceuticals and then distributed in hospitals (Langwick, 2011: 72). In 2002 the deputy minister of health referred to a recent visit to China, where he got inspired by the traditional medicine policy just like his political predecessors some thirty-five years ago. The parliamentary debates related to commodification of traditional medicines resulted in the Traditional and Alternative Medicine Act (2002), which was aimed at regulating the rapidly emerging demand for such services. As Langwick puts it, 'traditional medicine is no longer a site for the establishment of socialist nationhood; now it is an object subjected to the pressures of supply and demand' (Langwick, 2011: 72).

Quite in contrast with the times when self-reliance policy was an integral part of political rhetoric as was the commitment to healthcare for all, today in capitalist Tanzania 'the talk about traditional medicine is animated by spirit of entrepreneurship, a desire to break into the global market for herbal medicine, and the demands of the elite' (Langwick, 2011: 59). At the same time the government officials (as well as international NGOs) are prejudiced in favor of modern, scientific medical practice despite the efficacy of some indigenous healing methods (Mesaki, 1998). As a result, the Tanzanian government wants to integrate traditional and modern medicines, but doesn't seem to know how. Anyhow, the relations between modernity and governmental policies inherited from the colonial times continue to shape *uganga* today.

The increased standardization and institutionalization of *uganga* influence the etiological perceptions of *kifafa* as well as treatment decision-making. The pro-biomedical policy of the Tanzanian government, which is interested in clear-cut definitions of health-related afflictions, marginalizes and excludes those interpretations of *kifafa* that differ from the biomedical understanding. In other words, *kifafa* is sacrificed for the sake of epilepsy. The image of epilepsy as a stigmatizing illness produced by the pro-biomedical institutions within and outside the country attributes stigma to *kifafa* as well. The aim of these institutions is not to grasp the healing practices but to reshape them and make them cheaper and more convenient to manage.

Medical pluralism?

The concept of 'medical pluralism', which refers to the co-existence and sometimes adoption and integration of different medical systems, has been very popular within anthropology (cf. Slikkerveer, 1982; Johannessen & Lázár, 2006; Langwick, 2008). But is this concept still useful analytically? Stroeken (2012: 121) suggests that medical anthropologists should 'consider rejecting pluralism as the default platform of rural healthcare decisions and develop new, more appropriate nuances

within the empirical dimension’. He suggests a four-fold model for healthcare decisions in his Table 2. (Stroeken, 2012: 126).

In the table Stroeken shows the relationship between various medical epistemologies using such criteria as the type of transmission and the degree of openness of this or that epistemology to other medical practices. The transmission of an epistemology can be habitual (accepted as a cultural habit) and empirical (tested and experienced in the course of practice). Depending on how closed or open a certain healing epistemology is to other medical practices there are four healing systems, two of which are habitually transmitted and the remaining two are empirical. If an epistemology is closed, we can talk either about dualism (segregation) or monism (hierarchy between epistemologies); if it is open – about pluralism and radical empiricism.

Table 2. Four types of relation between, and transmission of, medical epistemologies.

Transmission	Relation	
	Closed	Open
Habitual	Dualism	Pluralism
Empirical	Monism	Radical empiricism

Stroeken argues that Sukuma ‘peasant intellectuals’ can be called radical empiricists both because they are open towards different medical domains and because they rely on traditional healers in the case of afflictions that biomedicine is least able to cure, notably ‘mental’ illness (2012: 120). Thus, these intellectuals do not only use all the medical resources available to them, but also do it very consciously (drawing from experience) and not just habitually. I witnessed the same healing epistemology (radical empiricism) in Kigamboni. The residents were very open towards various medical domains and practices but also relied on their experiences and the efficacy of the treatment. For example, the condition called ‘*degedege*’, which was believed to be a possible cause of *kifafa* was in most cases treated by traditional healers as, according to many respondents, biomedicine couldn’t cure it (see Chapter 3). Laughlin’s hypothesis that ‘the more a state of consciousness is oriented on direct experience, the fuzzier will be the categories informing experience’ (1993: 23) combined with Stroeken’s radical empiricism, explains the fuzziness of *uganga* in general and *kifafa* in particular. In the second chapter I will show that *kifafa* represents a fuzzy category for the residents of Kigamboni, who are radical empiricists.

Kamat (2008b), who did his research in a village within the Temeke district, also argues that in coastal Tanzania people are driven by experience and availability concerns rather than just perceived etiology of a certain condition. The author also questions the concepts of borders and the idea that people are more willing to search for treatment in faraway places. Sanders (2001), for example, argued that in Tanzania the practice of crossing ethnic, geographical and cultural boundaries seeking treatment was encouraged by the neoliberal reforms promoted by the World Bank and the IMF. Kamat doesn't deny the existence of the distant healing phenomenon, but he argues that it only takes place after all the local healing possibilities have been tried out and exhausted. According to him, the villagers didn't go to the local *waganga* because 'they had either found out on their own or had heard from others that the healers' therapy and medicines (*uganga*) were largely ineffective' (Kamat, 2008b: 112).

Thus the healing epistemology itself and *uganga* as the practice-related part of it are both very open and sometimes tricky in their indeterminacy and even vagueness. This openness is very much present in Kigamboni and is particularly visible in the treatment choices people make and the multiple etiological explanations of afflictions. The biomedical term 'disease' as a strictly defined physical disorder caused by a strictly defined action or substance, which is the same for every body it affects, cannot be used in the context of *kifafa*. In *uganga* there are few (if any) 'diseases'. There are conditions, which might have one name but can be caused by totally different forces or things in every particular case. In biomedicine bodies are standardized and disease is clearly determined symptomatically as is the treatment; in *uganga* every body is different, and the etiology and treatment are individual, which also explains the multiplicity of ideas around *kifafa* in Kigamboni. We shall elaborate on the etiological interpretations of this condition in the following chapter.

Conclusion

In pre-colonial times *uganga* and *uchawi* were not institutionally and epistemologically separated. Rather, they were perceived as a unified flexible bulk of practices largely inter-dependent. *Waganga* enjoyed respect and high social standing in their communities. Due to the nature of *uganga*, which is much more than healing physical bodies but also social and psychological treatment, it possessed considerable political power. The chiefs consulted diviners and were closely allied with them. The latter performed various socially important rituals like rainmaking and elimination of evil in general.

The warfare time associated with the migrations of the Ngoni contributed to the strengthening of *uganga's* position. Protective charms and war concoctions were believed to be essential for the

victory. Diviners were able to make use of the before unknown practices of the Southern Africa and enrich their magic arsenal.

Since the 1850s large caravans were covering huge distances in order to deliver the goods from the inland to the coast. *Waganga* were travelling with them, protecting both the caravan people and their loads. Geographical borders were crossed, opening the gates to the therapeutic knowledge of different ethnic groups inhabiting East Africa. *Waganga* learned from their counterparts, and this exchange of knowledge was gradually forming a new healer and his new client. The commodification process started in the late 19th century already, when the porters came back home with money received for their work. The roots of the healing individualization are also to be found in the pre-colonial period: travelling *waganga* could no longer 'fix' communities and fully engage in the social lives of their patients. Under the circumstances, herbalists must have benefited the most.

The early encounters of the European travelers with traditional healing systems formed an image of *uganga* as a malevolent and savage practice. Africa was perceived through a prism of binary oppositions aimed at promoting European superiority. Herbalism could be tolerated, but psychological and communal healing practices were baffling and incomprehensible. This image of *uganga* will influence the colonial policies later on.

The Maji Maji rebellion fully demonstrated the political importance of *waganga*, the lessons of the riot were learned by the Germans and the British who took over the power in Tanganyika. The new colonial administration fully realized the dangers of having *waganga* out of their control. The British legislation legally separated *uchawi* from *uganga* and thus deprived traditional medicine of its social functions; the healing was made an individual matter. In 1930s it was recognized that not all the diviners were witches and there was a shift in policy towards making use of the traditional healing knowledge. Yet it was implied that various types of *uganga* were not considered 'traditional medicine'. Only herbalism as a sort of 'pre-science' was acknowledged as useful for the development of healthcare. Here we see the perceptions of *uganga* formed in the mid 19th century already.

In the years following the independence in 1961 there has been no significant change in the discourse on witchcraft and traditional healing. Tanzania still uses the witchcraft ordinance from the colonial times. The structural adjustment reforms and the liberalization of the market have speeded up the ongoing processes of commodification and individualization of *uganga*. The social status of traditional healers is now much lower than it used to be in pre-colonial times. The caricature that you see below shows the attitude of some Tanzanians towards diviners. A woman asks a healer why he looks like a reggae singer. He answers: 'I truly am *mganga*. And this is just marijuana'.



Cartoon by Fadhi Mohamed (Retrieved from <http://kabwelacomix.blogspot.com>)

At large, modernity demands from *waganga* a completely new product: not the protection from malevolent forces, but traditional medicine in the form of a pill. Tanzanian government is influenced by the discourse of the WMF (World Monetary Fund), international NGOs, and the World Health Organization, prejudiced against spiritual and magic aspects of *uganga* but eager to promote herbalism. Once again we see how difficult it is to change the perceptions of healing that have roots in pre-colonial times. So far, *uganga* has been adopting to these perceptions, but at the same time influencing them. In this respect it is similar to Bourdieu's habitus.

In Kigamboni people have access to various healthcare facilities both biomedical and traditional. The healing epistemology and the medical practices of the residents are very open and usually driven by experience. Stroeken (2012) calls such healing cosmology radically empirical due to its acceptance of different medical practices and empirical nature. My informants could also be called radical empiricists, which is proved by the treatment choices they make (see Chapter 4).

The perceptions of *uganga* have been changing over the years but most of them have their roots in pre-colonial times. These perceptions still shape the policies of NGOs and governments in relation to healing as well as they influence the local etiology of afflictions, the treatment choices and medical epistemologies in general.

Chapter 2. Etiological interpretations of *kifafa*

Here I will discuss the perceptions of *kifafa* related to the symptoms and etiology. I will focus on the causes of *kifafa* as perceived by various groups of people, the symptoms of the illness and its 'age range'. I will also describe the opinions of the healing professionals on the *kifafa* etiology. Finally, I will address the explanations given by those who have *kifafa* and their caregivers. The aim of the second chapter is to demonstrate the great multiplicity of etiological explanations of *kifafa*, which co-exist with one another in the field of uncertainty. Not a single interpretation is dismissed due to the pluralism of *kifafa* itself that can be attributed to various conditions caused by different things, but still identified as '*kifafa*'. Thus, I argue that this misfortune can be called a fuzzy set.

This chapter will be mainly based on the results of my semi-structured survey, but also on open and semi-structured interviews with the residents of Kigamboni. For the sake of convenience I would like to divide the population into the following groups: people who are not directly affected by *kifafa*, people who have *kifafa* and their caregivers, and the healing professionals of Kigamboni. There are some differences between the people from these three groups in terms of the way they explain the etiology of *kifafa*. At the same time the symptoms of this condition are more or less equally described by all the informants. Thus, it appears that etiology of *kifafa* is obscure for many people, while the symptoms of this condition are well-known. *Kifafa* is often referred to as '*ugonjwa wa kuanguka*' (Sw., 'falling sickness'), which already gives an idea about the way it manifests itself.

When asked about the symptoms of *kifafa*, people usually mentioned the following: *kuanguka* (Sw., 'to fall'), *kutoa mapovu mdomoni* (Sw., 'to have foam in the mouth'), *kutafuna meno na ulimi* (Sw., 'to bite teeth and the tongue'), *kizunguzungu* (Sw., 'dizziness'), *kukojoa* (Sw., 'to urinate'), *kupoteza fahamu* (Sw., 'to lose consciousness'), *kutetemeka* (Sw., 'to tremble'), *kuzimia* (Sw., 'to faint'), *kujamba* (Sw., 'to emit digestive gases from the anus'), *kukakamaa* (Sw., 'to strain muscles'), *kutingisha mikono na miguu* (Sw., 'to shake hands and feet'). Most respondents both affected by *kifafa* and not, were able to give a thorough explanation of the symptoms of this condition. The opinion about the age boundaries of *kifafa* was also unanimous: both children and adults can have it, yet in most cases the condition starts in adolescence or adulthood.

When I probed further for the perceived causes of *kifafa*, most people were uncertain. Then I would ask to give the most plausible explanations they could think of. Fourteen causes of *kifafa* were mentioned by the respondents of the survey; some of them were more popular than the others but

they mostly cover the opinion plurality about *kifafa* etiology in Kigamboni. Here are the mentioned causes:

1. *Kichwa* (Sw., 'head'). Respondents who named the head as the source of *kifafa* meant that the cause was to be found in some malfunction of the head (an injury, for example). This cause was often paired with the *ubongo* explanation.
2. *Ubongo* (Sw., 'brain'). According to this opinion, the cause of *kifafa* lies in the brain, or to be more precise, in the brain disorder.
3. *Kurithi* (Sw., 'to inherit'). Some respondents thought that *kifafa* was '*ugonjwa wa kurithi*' (Sw., 'hereditary illness'), thus one could get it from a relative by heredity.
4. *Kuzaliwa nao* (Sw., 'born with it'). This explains *kifafa* as an inborn or a God-given condition, which doesn't have any physical cause and can befall anyone. People with *kifafa* are just born this way, it is bad luck. This explanation has nothing to do with *kurithi*, as the respondents declined the possibility of the hereditary nature of this condition.
5. *Uchawi/kurogwa* (Sw., 'witchcraft/to be bewitched'). *Kifafa* is caused by supernatural interference by an evil-doing *mchawi* or *mdudu* (Sw., 'witch').
6. *Ukosefu wa kinga* (Sw., 'deficit of immunity'). One respondent mentioned the lack of immunity as the cause of *kifafa*, adding that it is the same thing that causes HIV/AIDS. Indeed, HIV/AIDS in Swahili is '*ukosefu wa kinga mwilini*' (Sw., 'lack of immunity in the body') or UKIMWI. It must be stressed though, that this explanation of *kifafa*'s etiology is very rare.
7. *Majini/Mashetani* (Sw., 'genies/demons'). The cause of *kifafa* is spirit possession by genies or demons. Thus, this is also a supernatural explanation of *kifafa*'s etiology.
8. *Tumbo* (Sw., 'stomach'). According to some respondents, *kifafa* is a problem of the stomach. This explanation is often used by *waganga*, who say that there are snakes living in the stomach that during the seizure climb up to the head of the person who has *kifafa*, causing the loss of consciousness and temporal memory loss.
9. *Degegede*. *Degegede* is a condition that is believed to cause *kifafa*. Due to the fact that many respondents thought that it was the cause of *kifafa*, I shall address this condition more thoroughly in the third chapter of this thesis. Moreover, a lot of informants including traditional healers called *degegede* '*kifafa cha utoto*' (Sw., '*kifafa* of childhood'), meaning that it was the same condition as *kifafa* but it could only be found in children. The 'age range' of *degegede* was very ambiguous, but most respondents mentioned the age from one year to four years (but not more than ten). Some people though didn't believe that *kifafa* and *degegede* were the same in general with the only difference in the age of the patients.

10. *Majeraha ya kujifungua* (Sw., 'birth injury'). This explanation was given by one person only. The informant elaborated on this saying that a child could get *kifafa* if the nurse or the delivery assistant pulled the head of the baby in the wrong way.
11. *Mazingira, usafi, maji, chakula* (Sw., 'environment, hygiene, water, food'). I put these explanations together as they are all related to what is understood as *mazingira* (basically everything that surrounds a person, living conditions and nutrition at large). In other words, *kifafa* is caused by bad *mazingira*, which presupposes bad food, dirty water, poverty and bad living conditions.
12. *Kuvunja mwiko* (Sw., 'to break a taboo'). Some informants said that to get *kifafa* one has to break a taboo. Various taboos were mentioned, for example eating heads of fish or animals or urinating in the dump.
13. *Utoaji mimba* (Sw., 'abortion'). One respondent suggested that the mother who went through an abortion would have *kifafa*.
14. *Kifua* (Sw., 'chest'). One informant mentioned the chest as the place where the cause of *kifafa* is to be found.

Now that I have named all the fourteen causes of *kifafa*, I'd like to address the three groups of people that I mentioned earlier in order to see how the perceptions of *kifafa* differ between people with different experiences. I realize that I've made this chapter very detailed, but I did it for a reason. First of all, I wanted to analyze the survey population and try to understand what kind of people I was dealing with. Second of all, I was trying to show how complex, undefined, vague and unclear the etiology of *kifafa* is with all these multiple explanations supported simultaneously and the total acceptance of every possible interpretation. I must admit that I was hoping to put some structure to the explanation field; this chapter proves that one cannot structurize and organize something that is inherently unstructured. Thus, my failed attempt also adds to my argument about the ambiguous nature of *uganga* and the healing epistemology in Kigamboni.

People who are not directly affected by *kifafa*

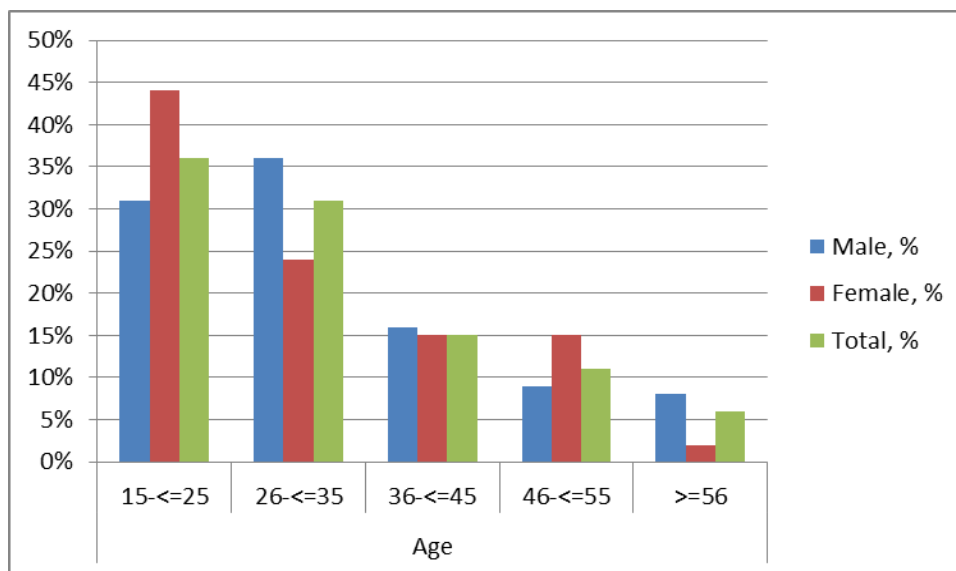
Analyzing the population

This population was mostly covered by the semi-structured survey, but I conducted a number of semi-structured and open interviews as well. The insights I got from the interviews are very similar to the results of the survey. I have 105 completed questionnaires, 64 (61%)¹¹ of which were filled in by men and 41 (39%) by women. I divided the survey population into five age groups: people who are

¹¹ In this thesis all numbers in the percentage format are rounded to whole

from 15 to 25 years of age (15-<=25); people who are from 26 to 35 (26-<=35); from 36 to 45 (36-<=45); from 46 to 55 (46-<=55); and those who are more than 56 (>=56).

Males of the first age group (15-<=25) make up for 31% of the 64 males, who participated in the survey; 36% of all men belong to the second age group (26-<=35); 16% to the third group (36-<=45); 9% to the fourth group (46-<=55); and 8% to the fifth group (>=56). With women the situation is a bit different: most of them (44%) are in the first age group; 24% got into the second group; 15% are in the third and the fourth groups; and only 2% of women are to be found in the fifth age group. We can also see this relationship between age and gender represented in Graph 1.¹² Along the abscissa of the graph we see the number of people and on the ordinate we find the five age groups; females are represented in red, males in blue, the total number of the respondents in green (see Graph 1).



Graph 1. Age and gender of the survey participants (%)

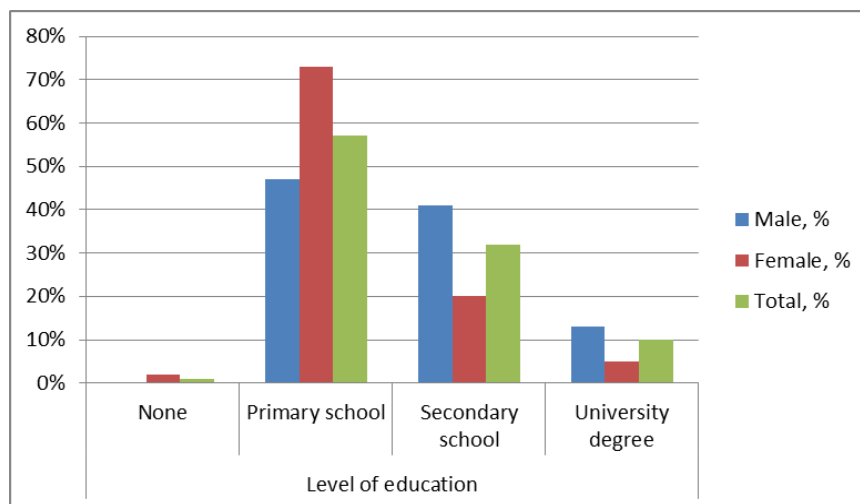
Thus, most participants were found in the first age group, followed by other groups. The older was the age, the fewer there were people of that age. This statement is true for women: most of them belong to the first group slowly decreasing in numbers as the age years increase. For men it's a bit different: most of them are in the second group, followed by the first group, and then by the third, fifth and the fourth groups respectively. Within each age group there are more men than women, except the third group (36-<=45), in which there are as many men as women.

In terms of education the survey population was divided as showed on Graph 2 (see below). Of all the respondents 57% got education up to the primary school level; 32% have a secondary school certificate; 10% have a university degree; only one respondent had no education at all. Out of all

¹² All the calculations and graphs used in this thesis were made in Microsoft Excel 2010

male participants 47% went to primary school; 41% finished secondary school; 13% had a university degree; there were no male respondents without any education. As for women, 73% of them have primary education; 20% went to secondary school; 5% got a university degree; 2% woman had no education at all.

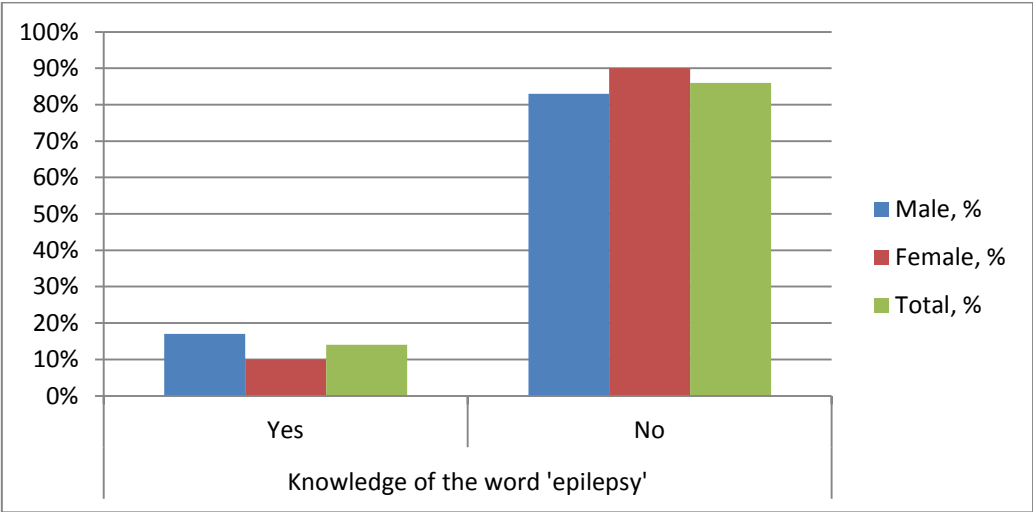
On Graph 2 we see that most survey participants went to primary school, followed by those who attended secondary school, universities or had no education at all respectively. As many women attended primary schools as men, but in case of secondary schools we see a salient gender discrepancy: much more men got secondary education than women did. The same tendency reveals itself in the case of universities (much more men obtained a university degree than women). Only one person had no education at all and it was a woman. The fact that most people (57% of all the participants) got primary education is explained by it being compulsory in Tanzania. The tuition for public primary schools was eliminated in 2002, which also contributed to the school attendance (Sacmeq, 2011).



Graph 2. Gender and the education levels of the survey participants (%)

The participants of the survey were asked if they were familiar with the English word 'epilepsy', and if so to explain if 'epilepsy' and '*kifafa*' were the same thing. All the informants who claimed they knew what 'epilepsy' was insisted that '*kifafa*' was the same. Certainly, knowing the English word didn't mean that the people were familiar with the symptoms of epilepsy, they just knew that '*kifafa*' was translated as 'epilepsy' into English. I subdivided the male and female survey participants into those who know what 'epilepsy' means (the 'Yes' part of Graph 3) and those who don't (the 'No' part of Graph 3). As we see, most people (86%) don't know what 'epilepsy' is. There are 83% of all the males and 90% of all the females who don't know about this word; 17% of men and 10% of women claim to know the word 'epilepsy'.

The knowledge of the word ‘epilepsy’ is more likely to be found in young people (from the first and the second groups) with a relatively high education level (from secondary school to university degree). This awareness doesn’t seem to be influenced by gender, as more than 80% of both men and women don’t know the word ‘epilepsy’, despite men being slightly more aware of it than women (17% and 10% respectively). This slight difference can be explained by the higher level of education among men in general (see Graph 2.).



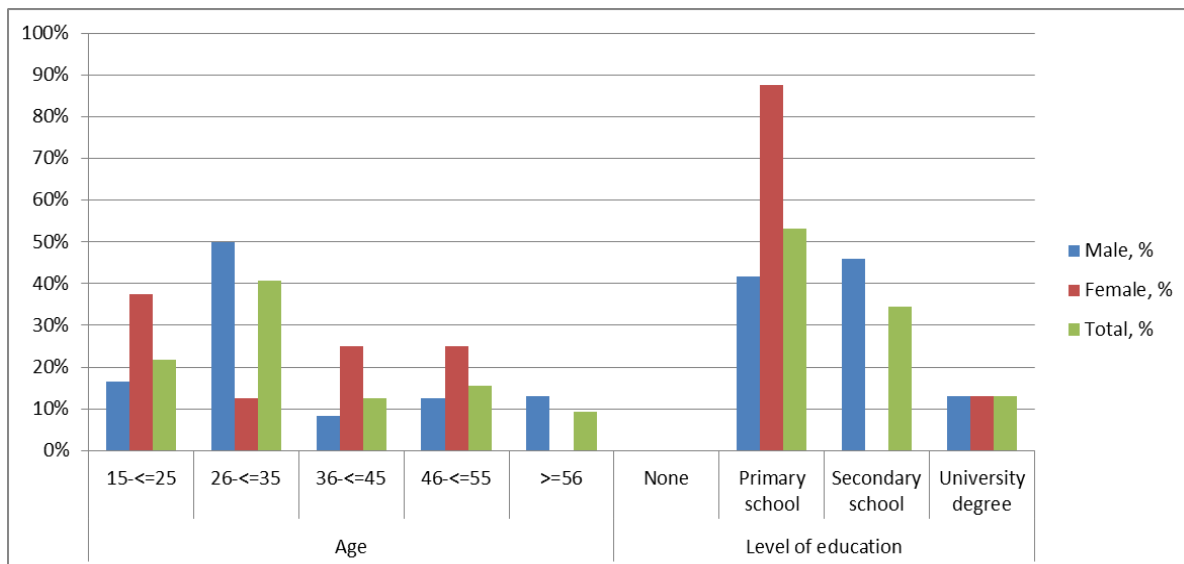
Graph 3. Gender and knowledge of the word ‘epilepsy’ of the survey participants (%)

People and perceived causes of *kifafa*

In this section I will analyze what kind of people support which explanation of *kifafa*’s etiology. It must be mentioned right away, that most people stick to a number of explanations and not just one however mutually exclusive these explanations might seem.

1. *Kichwa* (Sw., ‘head’)

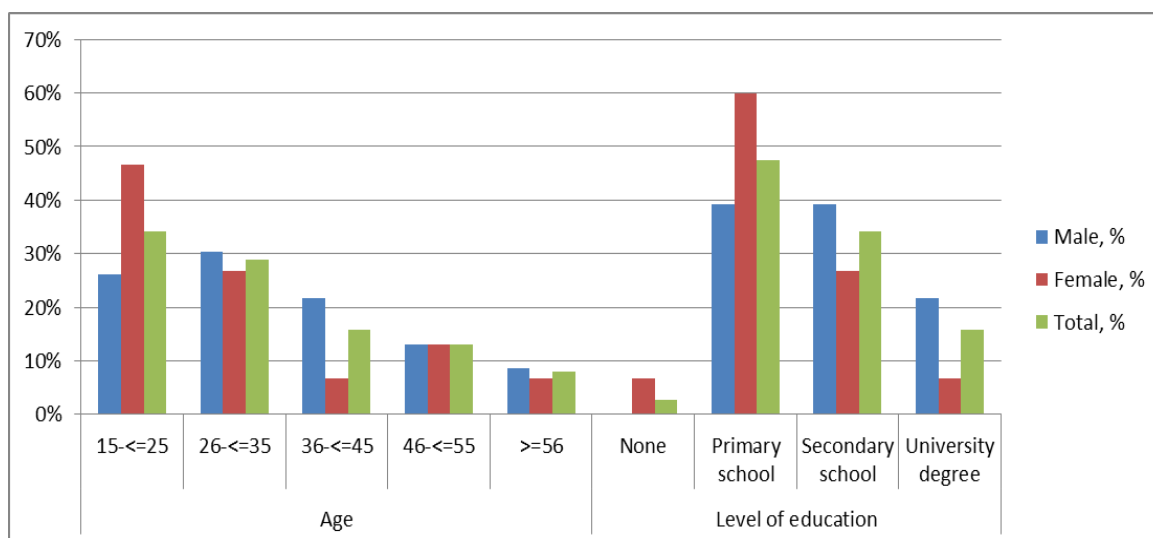
Quite some people (30% of all the respondents) mentioned that the cause of *kifafa* was in the head. It accounts for 38% of all the male survey participants, and 20% of all the female respondents. As we see on Graph 4, this explanation is more popular with men than with women; there is nobody in the ‘none’ education group who thinks that the first explanation is valid; most respondents (53% of those who supported this explanation) went to primary school, 34% attended secondary school, and 13% got a university degree. Most respondents (41%) belonged to the second age group followed by the first group (22%), the fourth group (16%), the third group (13%), and the fifth group (9%) respectively.



Graph 4. Gender, age and education level of the survey participants, who support the 1st explanation (%)

2. Ubongo (Sw., 'brain')

The second explanation was supported by 36% of all the survey participants, which accounts for 36% of all the males and 37% of all the females. So, the idea that *kifafa* is caused by some brain disorder is almost equally supported by men and women. Most respondents belong to the first age group, followed by the second, the third, the fourth and the fifth groups respectively. There is one uneducated woman (the only one who has no education out of the whole survey population of 105 people), who thinks that the malfunction of the brain can cause *kifafa*. Most respondents have primary education followed by those who got secondary education and those with a university degree respectively (See Graph 5).



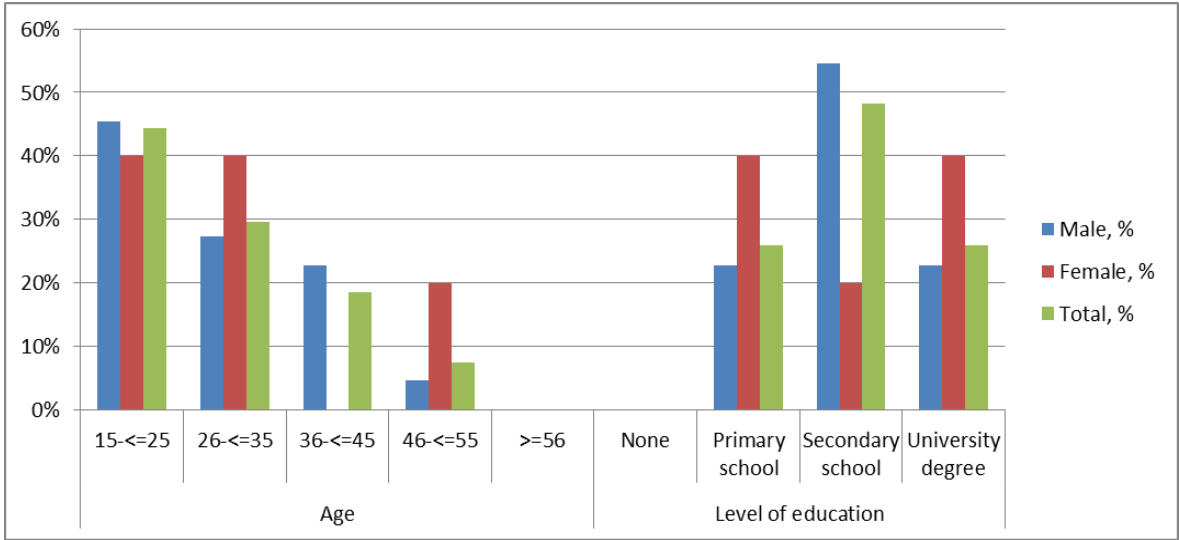
Graph 5. Gender, age and education level of the survey participants, who support the 2nd explanation (%)

Graph 5 represents the data in percentage and is made in the same manner as Graph 4. Most females who support the 2nd explanation went to primary school and belong to the first and youngest age group. Most males supporting this explanation are found in the second age group (which could also be due to the fact that most male survey participants belong to this group) followed by the first group. As for the education level, men with both primary and secondary educational backgrounds equally support the second interpretation of *kifafa's* etiology. Support for this interpretation is quite widespread among university graduates.

3. *Kurithi* (Sw., 'to inherit')

Kifafa is perceived as hereditary by 26% of all the respondents and 12% of all the female participants; 34% of all the male participants also supported the third interpretation. So, the *kurithi* explanation is more popular with men than with women. Most respondents are in the first age group, followed by the second, the third and the fourth groups respectively; nobody from the fifth age group thinks that the *kurithi* explanation of *kifafa* is valid (See Graph 6).

It appears that the third explanation is appealing for people with a relatively high education level. The *kurithi* explanation coincides with the biomedical idea of *kifafa's* etiology; high education level of those who named it as a possible cause of *kifafa* might be due to the influence of the biomedical discourse on the education programs in Tanzania. Men are also better educated than women (see Graph 2), which could explain the low percentage of females supporting the third explanation (12% only).



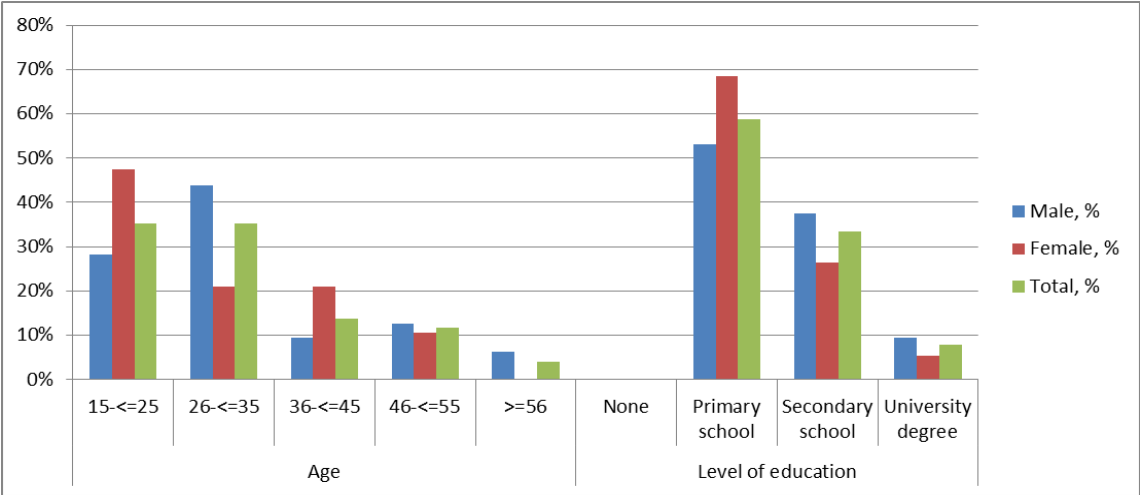
Graph 6. Gender, age and education level of the survey participants, who support the 3^d explanation (%)

On Graph 6., which was made in the same way as Graph 4 and Graph 5 we see that most males who support the *kurithi* explanation are found in the first age group, followed by the second, the third and the fourth groups respectively. As for females, as many of them belong to the first age group as to the second one; no female of the third and the fifth groups supports the third explanation, but there are some women from the fourth group who do. All women with a university degree of the whole survey population support the *kurithi* explanation; there are as many of them as those who have primary education. Most men supporting the hereditary etiology of *kifafa* went to secondary school.

4. *Kuzaliwa nao* (Sw., ‘born with it’)

The interpretation of *kifafa* as an inborn condition is very popular among the residents of Kigamboni: 49% of all the respondents support the fourth explanation of *kifafa*, which accounts for 50% of all the men and 46% of all the women who took part in the survey. Most people went to primary school and belong to the first and the second age groups; it appears that the fourth explanation is more likely to be supported both by men and women of young age with primary education.

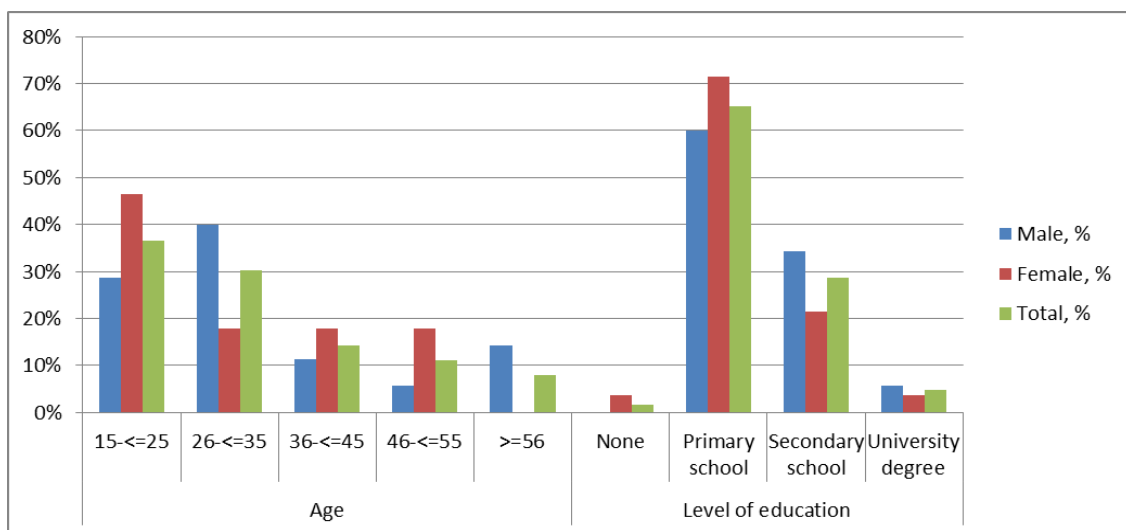
On Graph 7, which was made in the same way as the previous graphs (Graphs 4.-6.) we see that most males who support the fourth explanation are found in the second age group, followed by the first, the fourth, the third and the fifth groups respectively. As for females, as many of them belong to the second age group as to the third one; no female of the fifth group supports this explanation, but there are some women from the fourth group who do. Most females thinking that *kifafa* is inborn are found in the first age group. One woman with a university degree supports the *kuzaliwa nao* explanation; most men supporting the inborn-condition etiology of *kifafa* went to primary school, followed by those with secondary education and a university degree.



Graph 7. Gender, age and education level of the survey participants, who support the 4th explanation (%)

5. *Uchawi/kurogwa* (Sw., 'witchcraft/to be bewitched')

Witchcraft is a very widespread explanation of *kifafa*: 65% of all the survey participants named it as a possible cause. 55% of all the male survey participants and 68% of all the female respondents were positive about this interpretation. Thus, the *uchawi* explanation is very popular with both men and women, yet still more popular with females. The majority of the informants has primary education and belongs to the first age group. The fifth explanation is, thus, mostly popular among young people who have a relatively low education level and among women in general. It must be also noted that all the men from the fifth age group support the *uchawi* explanation.



Graph 8. Gender, age and education level of the survey participants, who support the 5th explanation (%)

On Graph 8, which was made in the same way as the previous graphs (Graphs 4-7.) we see that most males who support the *uchawi* explanation are found in the second age group, followed by the first, the fifth, the third and the fourth groups respectively. As for females, as many of them belong to the second age group as to the third and the fourth ones; no female of the fifth group supports this explanation. Most females in favour of the witchcraft explanation of *kifafa* are found in the first age group. One woman with a university degree and the only woman with no education both support the *uchawi* explanation. Most men supporting the witchcraft etiology of *kifafa* went to primary school, followed by those with secondary education and a university degree.

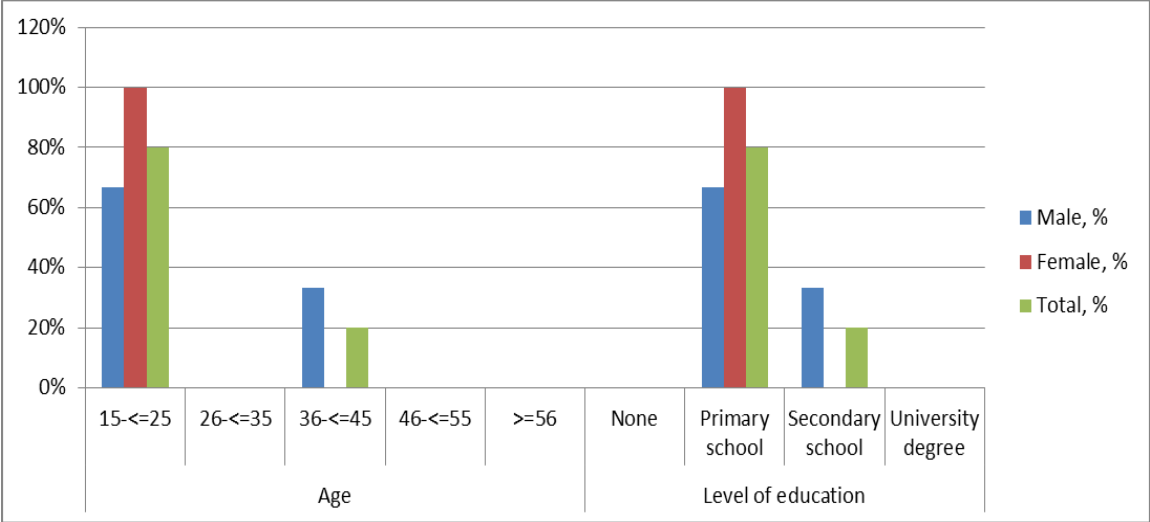
6. *Ukosefu wa kinga* (Sw., 'deficit of immunity')

Only one survey participant said that immunity deficit could be the cause of *kifafa* - a 30-year-old craftsman with primary education. He also mentioned that *kuzaliwa nao* (the fourth explanation) could be valid as a cause of *kifafa*. He further explained that the lack of immunity causing *kifafa* was

the same thing that caused HIV/AIDS. Interestingly, this respondent thought that *kifafa* wasn't contagious and was very positive about treating it biomedically.

7. *Majini/Mashetani* (Sw., 'genies/demons')

The *majini* explanation is rather rare: only 5% of the respondents suggested that it could cause *kifafa*. Yet, this interpretation is equally popular among men and women: 5% of all the men and 5% of all the women who participated in the survey supported this explanation. The majority of the informants has primary education and belongs to the first age group. The seventh explanation is, thus, mostly popular among young people who have a relatively low education level. It must be also noted that nobody with a university degree supports the *majini* explanation (See Graph 9).

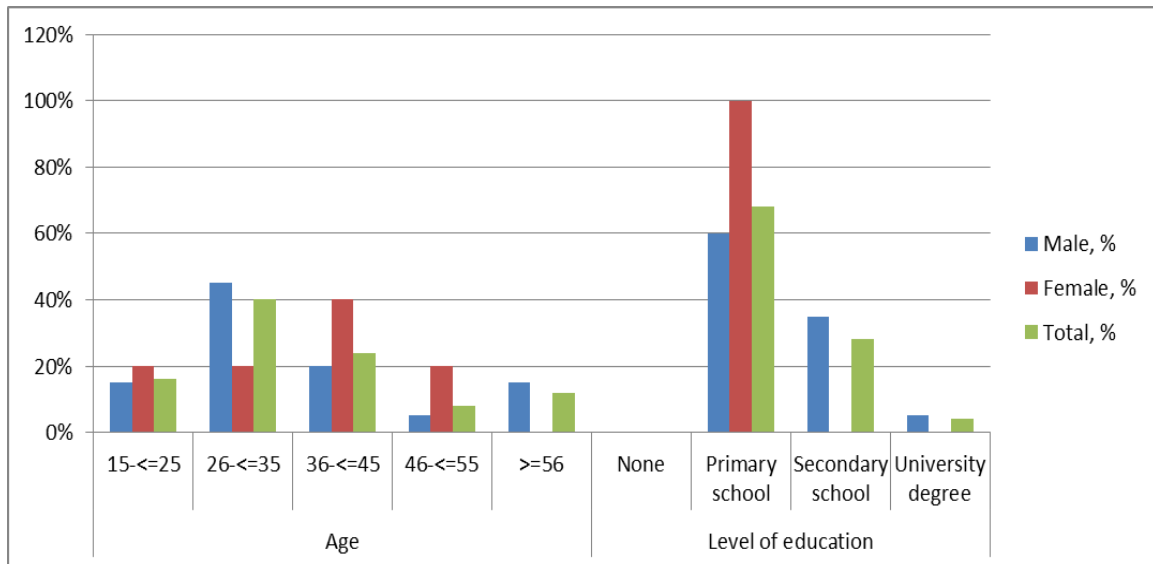


Graph 9. Gender, age and education level of the survey participants, who support the 7th explanation (%)

Most males who support the *majini* explanation are found in the first age group, followed by the third one; no men from other age groups support this interpretation. As for females, all of them belong to the first age group and have primary education. Most men supporting the *majini* etiology of *kifafa* went to primary school, followed by the only person with secondary education.

8. *Tumbo* (Sw., 'stomach')

Twenty-four percent of the survey participants explain *kifafa* as a stomach problem, which accounts for 31% of all the male respondents and 12% of all the female informants. Thus, this interpretation is more popular with men than with women. The majority of the informants has primary education and belongs to the second age group. The eighth explanation is, thus, mostly popular among young people who have a relatively low education level. It must be also noted that only one person with a university degree supports the *tumbo* explanation (See Graph 10).



Graph 10. Gender, age and education level of the survey participants, who support the 8th explanation (%)

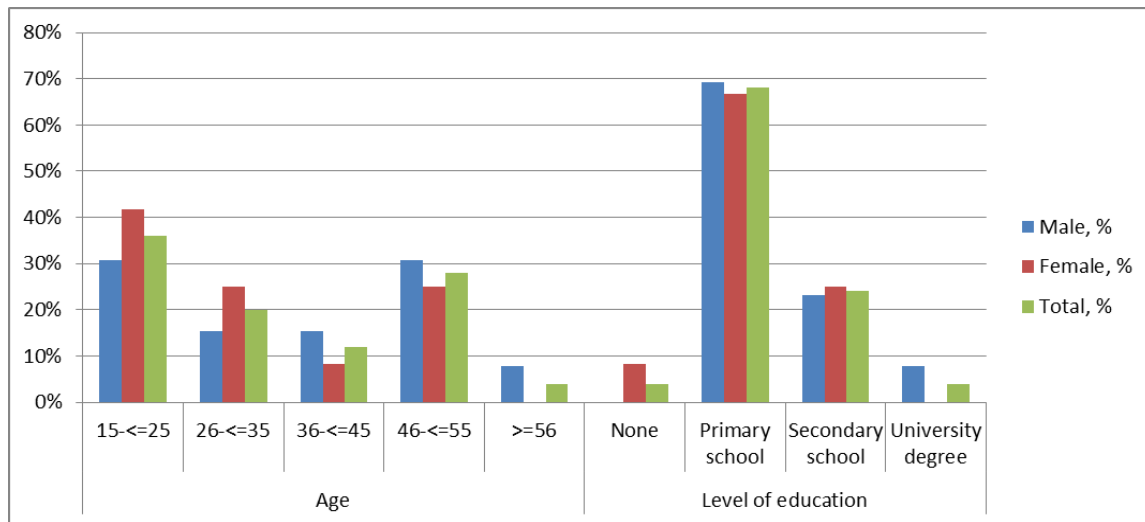
On Graph 10 we see that most males who support the *tumbo* explanation are found in the second age group, followed by the third one, then by the first and the fifth groups, which have the same number of informants, and the fourth group respectively. As for females, as many of them belong to the first age group as to the second and the fourth ones; no female of the fifth group supports this explanation. Most females in favour of the stomach explanation of *kifafa* are found in the third age group. All the women who support the *tumbo* explanation have primary education. Most men supporting the stomach etiology of *kifafa* went to primary school, followed by those with secondary education and a university degree.

9. *Degegege*

As I mentioned before, I will address the condition of *degegege* and its relation to *kifafa* in the next chapter. Here it will be sufficient to say that 24% of all the respondents named *degegege* as a cause of *kifafa*; it accounts for 29% of all the women and 20% of all the men. The majority of the informants has primary education and belongs to the first age group. The ninth explanation is, thus, mostly popular among young people who have a relatively low education level. It must be also noted that only one person with a university degree supports the *degegege* explanation.

On Graph 11 we see that most males who support the *degegege* explanation are found in both the first and the fourth age groups, followed by the second and the third groups, which have the same number of informants, and the fifth group respectively. As for females, as many of them belong to the second age group as to the fourth one; no female of the fifth group is in favour of this explanation. Most females supporting the *degegege* explanation of *kifafa* are found in the first age

group. Most women who opt for the ninth explanation have primary education, followed by those who have secondary education and the only woman with no education; no female with a university degree supports this interpretation. Most men supporting the *degedege* etiology of *kifafa* went to primary school, followed by those with secondary education and a university degree.



Graph 11. Gender, age and education level of the survey participants, who support the 9th explanation (%)

10. *Majeraha ya kujifungua* (Sw., 'birth injury')

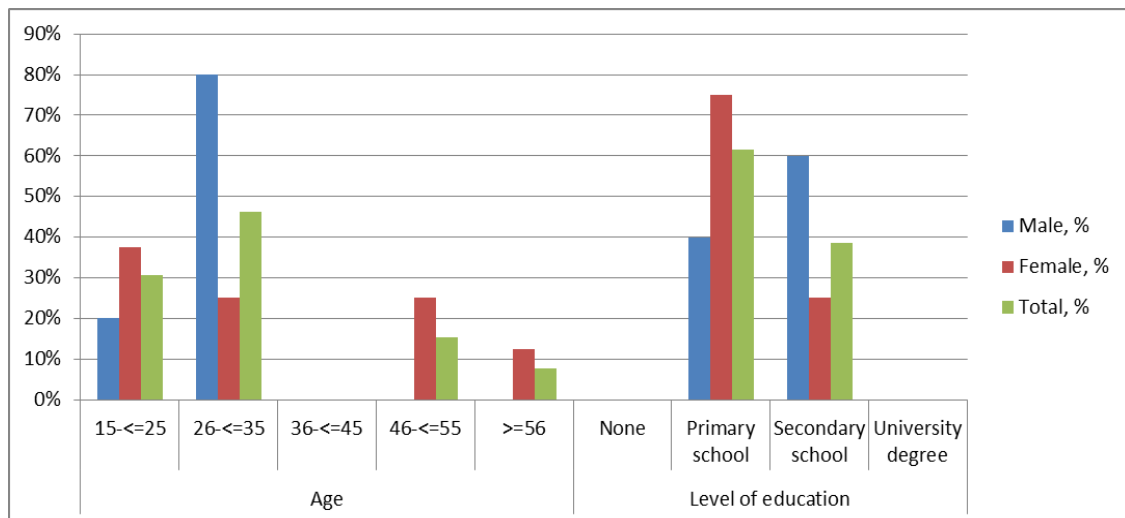
The only person to have mentioned birth injury as a way of causing *kifafa* was a 55-year-old tradeswoman with primary education. She was also the only survey participant who suggested the *kuvunja mwiko* explanation; she said it was possible that the *kichwa*, *uchawi* and *mazingira* interpretations could be valid as well. The woman was sure that *kifafa* was contagious and thought that traditional medicine was more likely to cure this condition than biomedicine.

11. *Mazingira, usafi, maji, chakula* (Sw., 'environment, hygiene, water, food')

This explanation is not a very popular one: only 12% of all the survey participants supported it; it accounts for 8% of all the male participants and 20% of all the female informants. So, the eleventh explanation is more widespread among women than among men. The majority of the informants has primary education and belongs to the second age group. It must be also noted that nobody with a university degree supports the *mazingira* explanation.

Graph 12 shows that most males who support the *mazingira* explanation are found in the second age group, followed by the first one. As for females, as many of them belong to the second age group as to the fourth one; most women belong to the first age group. There are no females or males in the third group who favour this explanation. Most women who support the eleventh explanation have

primary education, followed by those who have secondary education; there aren't any respondents with no education and with a university degree. Most men supporting the *mazingira* etiology of *kifafa* went to secondary school, followed by those with primary education.



Graph 12. Gender, age and education level of the survey participants, who support the 11th explanation (%)

12. *Kuvunja mwiko* (Sw., 'to break a taboo')

Once again there was only one survey participant who thought that breaking a taboo could cause *kifafa* (the same woman who suggested the tenth explanation). She mentioned urinating into the dump, shade or the ocean as actions that could result in *kifafa*. Although she was the only survey-participant to have mentioned *kuvunja mwiko* as an explanation for *kifafa*, my other informants also supported breaking a taboo as a possible reason for getting this condition. I shall return to the twelfth explanation later in this chapter.

13. *Utoaji mimba* (Sw., 'abortion')

This explanation suggests that a mother who has her baby aborted is running the risk of getting *kifafa* as a punishment for it. In this sense, *utoaji mimba* is basically the same as breaking a taboo. Abortion is illegal in Tanzania and punished by 14 years of imprisonment for the person who administered it and 7 years for the woman (Plummer et al, 2008: 281). According to Plummer et al, abortion is a 'highly stigmatized and hidden' practice, which is yet widespread in Tanzania (Ibid.: 284). Women who aborted their children without the consent from the children's fathers were thought to be later on killed by the ancestors of the fathers' clans (Ibid.: 285). Thus, the *utoaji mimba* explanation appears to be closely intertwined with the *kuvunja mwiko* interpretations; at that, both the explanations are the outcomes of making the ancestors angry.

The thirteenth explanation was mentioned only once in the course of my fieldwork. A 19-year-old housewife with primary education said that she thought that an abortion could give *kifafa* to the

woman who went through with it. She was also sure that *kifafa* was contagious and could only be treated by *mganga*.

14. *Kifua* (Sw., 'chest')

A 71-year-old male administrative clerk with primary education mentioned the *kifua* explanation along with the *uchawi* and *tumbo* interpretations. He was the oldest survey participant and the only person who suggested the fourteenth etiology version. He thought that *kifafa* was contagious and could be cured by traditional medicine.

People who have *kifafa* and their caregivers

In this section I will address the causes of *kifafa* stated by people who have this condition and their caregivers. As a rule, people would name more than one cause; yet, their etiologies of *kifafa* are not as multiple and ambiguous as those represented earlier. People facing *kifafa* directly and dealing with it on every day basis have more clear perceptions of their conditions than the people from the previous group; they also suggest fewer explanations simultaneously than those from the first group. Here I will rely on the data gathered using semi-structured interviews. It seems logical to structure this section the same way as the previous one – by the perceived explanations of *kifafa*.

1. *Kichwa* (Sw., 'head')

This explanation was mentioned by a close female friend of Saidi Juma Saidi, a 41-year-old male with *kifafa*. She thought it was the most plausible explanation because after seizures Saidi lost his memory for a while, which she interpreted as a problem of the head.

2. *Ubongo* (Sw., 'brain')

This interpretation was given by 6 (2 men and 4 women) of the 11 (5 women and 6 men) people with *kifafa*. They all admitted that they got this idea from the doctors, which falls in line with the biomedical etiology of *kifafa*. Those who never went to doctors hardly ever mentioned the *ubongo* explanation.

4. *Kuzaliwa nao* (Sw., 'born with it')

The fourth explanation was only mentioned by Hamis Osman Hamis, a 27-year-old man with *kifafa*. He wasn't very sure about it though, saying that he never thought of the causes of his condition.

5. *Uchawi/kurogwa* (Sw., 'witchcraft/to be bewitched')

Nine people (5 females and 4 males) with *kifafa* named witchcraft as the cause of their condition. All of them addressed *waganga* for treatment at some point of their lives.

7. *Majini/Mashetani* (Sw., 'genies/demons')

The seventh explanation was suggested by the mother of Mwarami Shiamte, a 19-year-old male, who himself was absolutely sure that he was bewitched. Yet, it should be noted that both the mother and the son opted for supernatural etiology of *kifafa*.

8. *Tumbo* (Sw., 'stomach')

The mother of Jamsi Ali, a 25-year-old male, thought that the cause of her son's *kifafa* was in the stomach. She thought so because the seizures usually started with the rumbling of the stomach.

9. *Degedege*

Six people (3 females and 3 males) thought that *degedege* was the cause of *kifafa*.

12. *Kuvunja mwiko* (Sw., 'to break a taboo')

Two men suggested that the breaking of a taboo could be a cause of *kifafa*. The first one was Mohamed Salum, a 23-year-old, who said that he heard that eating cuttlefish (Sw., '*mkizi*') could cause *kifafa*. Mohamed went on to say that it was considered bad to eat the heads of birds, animals and fish, as this could give one *kifafa*. When asked if he ever met anyone who got *kifafa* this way, he said he never did. Yet, to be on the safe side, people usually threw away the heads. The second person who mentioned the twelfth explanation was a 41-year-old Saidi Juma Saidi. He was convinced that his grandmother was *mchawi*, which resulted in him getting *kifafa* as punishment for her evil-doing.

Waganga of Kigamboni

I interviewed 5 healing practitioners of Kigamboni (3 females and 2 males). All of them said that *degedege* and *kifafa* were the same conditions but of different age groups: *degedege* was found in children only and *kifafa* in adults. Every *mganga* was sure that a child who had *degedege* would have *kifafa* afterwards. Along with the ninth explanation, the *tumbo* and *uchawi* interpretations were mentioned by all the healers except the female Siwatu Hija, who thought that the *ubongo* explanation was the right one. All the healers said that *kifafa* was contagious through *upepo* (Sw., 'wind'), by which they meant the inhaling of the digestive gases from the anus of the person with *kifafa*. As for other interpretations, the healers didn't discard them; they didn't mention them either,

though. It was due to the nature of the diagnosing process, which was based on divination. In every particular case the cause of *kifafa* was different and had to be determined by *ramli* (Sw., 'divination') for a particular patient.

Conclusion

The symptoms of *kifafa* are well-known to most residents of Kigamboni and it is very easy for the people to list them. But when it comes to explaining the causes, most people find it difficult; some have to think hard before they come up with an explanation. During my fieldwork I came across fourteen different explanations of *kifafa*'s etiology: *kichwa* (Sw., 'head'), *ubongo* (Sw., 'brain'), *kurithi* (Sw., 'to inherit'), *kuzaliwa nao* (Sw., 'to be born with it'), *uchawi* (Sw., 'witchcraft'), *ukosefu wa kinga* (Sw., 'deficit of immunity'), *majini* (Sw., 'genies'), *tumbo* (Sw., 'stomach'), *degedege, majeraha ya kujifungua* (Sw., 'birth injury'), *mazingira* (Sw., 'environment'), *kuvunja mwiko* (Sw., 'to break a taboo'), *utoaji mimba* (Sw., 'abortion'), and *kifua* (Sw., 'chest'). Some of these explanations are related to each other (e. g. breaking a taboo and getting an abortion), some are explicitly biomedical (e.g. *ubongo* and *kurithi*), while other interpretations are related to supernatural causes (e. g. *uchawi, majini*); some explanations relate to particular body parts (e.g. head, stomach, chest). Despite somewhat controversial and sometimes mutually excluding (it may seem) nature of the causes, people almost always suggest them together. It might be due to individualistic approach to *kifafa*, the etiology of which changes in every particular case. The word '*kifafa*' thus relates to certain symptoms, which are more or less the same for everyone with this condition, but not to the same etiology. Every case of *kifafa* is considered to have different (and sometimes multiple) causes, which allows for the etiological plurality in Kigamboni.

We find the greatest variety of *kifafa*'s etiological interpretations among people who are not directly affected by this condition. The fourteen explanations are rated in the following way by their popularity (from the most popular to the least popular):

1. *Uchawi* (explanation 5). 60% of the survey participants supported this interpretation, which accounts for 55% of women and 68% of men. This explanation was more popular with males than with females and was widespread among young people with primary education. It should also be noted, that all the male survey participants of the fifth age group supported this cause of *kifafa*.
2. *Kuzaliwa nao* (explanation 4). 49% of the survey participants mentioned the fourth interpretation; it accounts for 50% of all men and 46% of all women. This explanation was

almost equally popular among the genders and predominant among the youth with primary education.

3. *Ubongo* (explanation 2). 36% (36% of all men and 37% of all women) of the survey respondents suggested this explanation. This biomedical interpretation was equally popular among the genders and was supported by most of the participants with a university degree. This biomedical interpretation is supported by the educational system of Tanzania, which is not surprising given the structural adjustment reforms of the 1990s.
4. *Kichwa* (explanation 1). 30% of the survey participants or 38% of all males and 20% of all females mentioned the first explanation of *kifafa*. It was more popular with men than with women and among the participants with primary education. Most respondents supporting the *kichwa* interpretation were found in the second age group.
5. *Kurithi* (explanation 3). *Kurithi* is supported by 26% of the survey participants (34% of all males and 12% of all females). This biomedical explanation is predominant among men rather than women and young people with secondary education. Most informants with a university degree also supported this interpretation. Once again we see how education as a pro-biomedical institution constructs the etiology of *kifafa*.
6. *Tumbo* and *Degegede* (explanations 8 and 9 respectively). Both the explanations are supported by 24% of the survey participants; the eighth interpretation is more popular with men (31% of all males) than with women (12% of all females) and is prevalent among young people with primary education. The *degegede* explanation is supported by 29% of all women and 20% of all men, which means that this interpretation is more popular with the female respondents. Just like the *tumbo* cause, the ninth explanation is widespread among the young people with primary education.
7. *Mazingira* (explanation 11). 12% of the survey informants suggested this explanation; it accounts for 8% of all men and 20% of all women, thus making it more popular with females. Nobody with a university degree supported this interpretation, while many young people with primary education did.
8. *Majini* (explanation 7). This interpretation was supported by 5% of the survey participants (5% of men and 5% of women). Once again, young people with primary education mostly suggested it.
9. *Ukosefu wa kinga, Majeraha ya kujifungua, Kuvunja mwiko, Utoaji mimba, and Kifua* (explanations 6, 10, 12, 13, and 14 respectively). All these explanations were suggested by one person only; each of them accounts for 1% of the survey participants.

As for people with *kifafa* and their caregivers, they suggested eight interpretations of *kifafa*'s etiology: *kichwa* (1 woman mentioned it), *ubongo* (6 people supported it: 2 men and 4 women), *kuzaliwa nao* (1 man mentioned it), *uchawi* (9 people suggested it: 5 women and 4 men); *majini* (1 woman mentioned it); *tumbo* (1 woman); *degedege* (6 people: 3 men and 3 women), and *kuvunja mwiko* (2 males). Thus, *uchawi* is the most popular explanation, followed by *ubongo* and *degedege*, which are equally popular. The *ubongo* interpretation is widespread among those who went to doctors for treatment and got this explanation from them. The five remaining explanations are less predominant.

The etiological field of explanations around *kifafa* (which can be called a fuzzy set) is very vast and even confusing but not surprising given the very nature of *uganga* and the healing epistemology of Kigamboni. The ambiguities and the multiplicity of interpretations, which the local medical habitus allows for, are integral for the healing cosmology itself and for its reproduction. *Waganga* play their part in forming the perceptions about *kifafa* and support the existent epistemology with their treatment, which varies for every *kifafa* case and brings about uncertainty. Pro-biomedical institutions (education and the Tanzanian government) are struggling to minimize the uncertainty and to promote their own etiology of *kifafa*, which totally identifies it with epilepsy. Most of my informants, however, didn't see the ambiguity of *kifafa* as a problem; rather they took it as something inherent, which couldn't be helped.

All the traditional healers I interviewed suggested the *degedege*, *tumbo* and *uchawi* causes of *kifafa*, noting that *degedege* was just *kifafa* of the children. Only one female healer said that the cause of *kifafa* was brain disorder (the *ubongo* cause), yet she confirmed that *degedege* was the same thing as *kifafa* and that she treated both conditions in a similar way. Other explanations were not mentioned but were not discarded; the cause was determined through divination and was different for every patient. Thus, the *uchawi* explanation is predominant in all the three population groups; the *degedege* and *ubongo* causes are popular with people who have *kifafa* and their caregivers, while *uchawi*, *tumbo* and *degedege* are equally predominant among traditional healers. It appears essential to look at the condition called '*degedege*' in more details in order to see how it is related to *kifafa* and understand its etiology. This shall be done in the third chapter.

Chapter 3. *Kifafa* and *Degedege*

In the previous chapter we established that many residents of Kigamboni who are not directly affected by *kifafa*, those who have it, and traditional healers attribute its cause to the condition called *degedege*. I will describe its symptoms, ‘age range’, and the medicines used to treat it. In addition to this I will analyze the relationship between *degedege*, *kifafa* and biomedical malaria. The third chapter will show how influential the biomedical discourse is in associating *degedege* with malaria but neglecting the vast field of other etiological interpretations of *kifafa*. This is done as an attempt at reducing the fuzziness of *kifafa* and bringing it under the biomedical gaze. *Degedege* is not represented as a stigma-related illness in the literature due to its relationship with malaria, which is not seen as causing stigma. Once again we will find that the etiological pluralism of *kifafa* is reduced first to *degedege* and then to the clear and structurally acceptable malaria.

The Swahili word ‘*degedege*’ is translated as ‘convulsions’, while its etymology from the word ‘*ndege*’ (Sw., ‘bird’) is not only obvious, but also closely related to the etiology of this condition. In the literature devoted to *degedege* (febrile convulsions or severe/cerebral malaria as it is called in biomedicine) we find that some people in Tanzania think that this condition is caused by an evil spirit (*shetani*), which ‘takes a form of a bird and casts its shadow on vulnerable children on moonlit nights’ (Kamat, 2008a: 72). The affected children start to convulse, develop fever, their eyes turn white, and the body stiffens (cf. Comoro et al, 2003; Gessler et al, 1995; Hausmann Muela et al, 2002; Kamat, 2006, 2008a; Makemba et al, 1996; Tarimo et al, 2000; Winch et al, 1996). Interestingly, the ‘flying’ explanation of febrile convulsions is not unique for Tanzania: Sarah Castle (1994) describes the condition of *foondu* in Mali, which is very similar to *degedege* in its symptoms and etiological interpretation – an owl flying at night is perceived as a cause. In order to see how *degedege* is related to *kifafa* it is necessary to look at its symptoms, etiological interpretations, preferred treatment and age range.

Symptoms and perceived etiology

When I asked my informants to compare *degedege* and *kifafa*, most of them said that the two conditions were very similar (Sw., ‘*yanafanana sana*’), but noted that *degedege* was a childhood condition (Sw., ‘*ugonjwa wa kitoto*’). According to them, this affliction was prevalent among children up to the age of 4-5 years, which goes in line with *degedege*’s age range in literature (Dillip et al, 2012; Langwick, 2007; Comoro et al, 2003; Makemba et al, 1996; Nsimba & Kayombo, 2008; de

Savigny et al, 2004). This is how Ramadhani Furumani, a 34-year-old male servant with primary education, describes the symptoms of *degedege* and compares them with those of *kifafa*:

The child's body becomes very dry (Sw., '*anakauka*'); soon a high fever starts, eyes become big. It's similar to *kifafa*, the child can lose consciousness and convulse but it doesn't froth at the mouth (Sw., '*hatoi mapovu mdomoni*'). *Kifafa* has no age; *degedege* is the condition of children. If you take a child with *degedege* to a hospital and they give it injections, the child will die. *Degedege* should be treated by *waganga* with herbs (Sw., '*mitishamba*'). *Degedege* is caused by malaria but the cause of *kifafa* is obscure (From the interview on July 4, 2012).

Even without doing further research we can conclude from the words of Ramadhani that Kigamboni is a place where both traditional medicine and hospital services are available to the residents. Ramadhani is obviously influenced by the biomedical discourse, leading him to attribute *degedege* to malaria. At the same time he is convinced that injections in the case of *degedege* are fatal, which corresponds with the traditional understanding of this condition related to spirit possession (cf. Langwick, 2007).

The symptoms of *degedege* described in literature (Kamat, 2008a: 73; Dillip et al, 2012: 4; de Savigny et al, 2004: 7) usually include the following: high fever, twitching, loss of appetite, stiffness of the body, white eyes, dehydration and frothing at the mouth. These symptoms are indeed similar to those of *kifafa* and epilepsy, though these are not febrile condition. Despite these similarities epilepsy is hardly ever mentioned in the literature on *degedege*, where the latter is in most cases dichotomized with malaria (Nsimba & Kayombo, 2008: 321).

The fact that *degedege* is covered by literature is very interesting, as there are so many other explanations and interpretations both around *kifafa* and *degedege*, which we don't find in academic publications. I have come across fourteen etiological interpretations of *kifafa*, yet only one of them is discussed in literature. The popularity of *degedege* among scholars is very much defined by the identification of this condition with malaria, which is not only a biomedical disease but also a widespread illness. Writing about malaria-related *degedege* is popular largely due to the availability of resources allocated for fighting malaria in Africa.

Another point worth making is that we don't read about stigma related to *degedege* in the literature, which is due to the identification of this condition with cerebral malaria. Malaria is not seen as stigmatizing by the academia, which explains why *degedege* is never attributed to stigma. Given the symptomatic similarity of *kifafa* and *degedege* (and the fact that it is very hard for the laypeople to tell one from the other) it is then inconsistent to claim that the former is stigmatizing and the latter is not. My research shows that neither of these conditions is related to stigma and discrimination. I

argue that pro-biomedical institutions label *kifafa* as stigmatizing just basing on the assumption that this condition is identical to epilepsy. Symptomatically, it indeed may be so, but etiologically, socially and culturally these conditions are different.

Thus, most scholars use biomedical lens as their starting point; if *degedege* wasn't associated with biomedical malaria, we probably wouldn't have literature on this condition at our disposal. This makes the coverage of *degedege* in literature very accidental: the other multiple causes of *kifafa* are neglected by the academia mostly because they do not add to the biomedically triggered malaria debate. Once again we see multiplicity denied by the biomedical discourse while it is this very plurality that makes the local healing epistemology work. In this thesis I use a different approach to afflictions or rather conditions: I am not interested in comparing *kifafa* and epilepsy or *degedege* and malaria. What I am fascinated with is listening to people and familiarizing myself with the local ideas around a particular condition called '*kifafa*'.

Epilepsy was briefly mentioned by Langwick (2007: 93) when she was talking about the etiology of *degedege* as perceived by the nurses of the Newala District Hospital (South-East Tanzania), who thought that *degedege* could be a symptom of epilepsy along with malaria, meningitis, 'or any infection that results in a very high fever'. Makemba et al (1996: 309) agree with the nurses saying that symptomatically *degedege* could be diagnosed as 'febrile convulsions, epilepsy, cerebral malaria or meningitis'.

Very much like the concepts of 'tradition' and 'modernity', *degedege* and malaria 'are identified, shaped, and elaborated in relationship with each other' (Langwick, 2007: 89). Despite being attributed to the same physical symptoms (Ibid.), *degedege* and malaria are yet interpreted very differently, which shapes the treatment strategies in (it may seem) unexpected ways. For example, traditional healers see *degedege* as the work of evil spirits (Sw., '*mashetani*') and condemn injections as fatal; biomedical doctors on the contrary attribute it to malaria and prescribe chloroquine shots.

Though most people think that *degedege* is predominant among children only, some authors argue that this condition can befall adults as well (Makemba et al, 1996: 308; Langwick, 2007: 93). The majority of my informants insisted on *degedege* being *ugonjwa wa kitoto* (Sw., 'childhood condition') and declined the possibility of an adult getting it. Only one of my informants, a 19-year-old uneducated Zula Asan, mentioned that *degedege* in an adult was a sign of witchcraft (Sw., '*dalili ya uchawi*'). Kamat (2008a: 72) stresses that *uchawi* is not usually associated with *degedege* as the spirit bird picks its victims at random. Interestingly, most informants said that *degedege* was a curable condition, while *kifafa* was not. It could be alleviated but not overcome completely.

The etiology of *degedege* is not as various in terms of causes as *kifafa*'s etiology, but the literature (Kamat, 2008a; Langwick, 2007; Dillip et al, 2012; de Savigny et al, 2004; Comoro et al, 2003) suggests the following local interpretations: the spirit bird (or *shetani*), *uchawi*, malaria, *kuvunja mwiko* (in this case failure to abstain from sex), and *mazingira* (here mostly related to the places where mosquitoes breed). The most popular explanations are malaria and *shetani*, which correlate with biomedical and traditional etiologies respectively. These two explanations were predominant among my informants as well; it must be noted though, that *uchawi* always remains a possible explanation and is never dismissed.

Makemba et al (1996: 309) describe an interesting division between different types of *degedege*. According to them, there is 'the big one and the small one'. The former is called *bane*, the latter is referred to as *mkulu hatambulwa*; subsequently, this *mkulu* is divided into two forms – male and female. The symptoms of *bane* described by Makemba's informants remind of the *kifafa* symptoms: an adult falls down, 'he urinates and defecates and saliva comes out of his mouth' (Ibid.). The *mkulus* are usually diagnosed according to which side of the patient's body convulses more; in the case of the male *mkulu* it is the right side, while female *mkulu* manifests itself in the twitching of the left side of the body.

According to one of Makemba's informants, *degedege* is caused by the spirit called *Al-hamar al-miriih*, who 'rides on the back of a horse and comes in the cold south wind that blows during the rice harvest season' (Makemba et al, 1996: 310). This spirit is also thought to be living in big trees, from where he can attack children. One of the traditional healers I interviewed Mzee Ally Mzee was sure that the *degedege* spirit was coastal (Sw., '*kutoka pwani*') and came when the winds blew from the seashore. Another *mganga* named Ibla told me that his helping spirit (Sw., '*mzimu*') lived in the sausage tree (Sw., '*mwegea*' or *Kigelia Africana*) right next to his house. Through a number of open interviews I learned that big trees like baobab (Sw., '*mbuyu*') or banyan (Sw., '*banyani*') were thought to be sources of power for *waganga* but also for *wachawi*, for which were feared and avoided.

My research assistant Johnny Shabani explained to me that people who lived next to baobabs were suspected of doing witchcraft unless they were known as traditional healers. This belief goes further than Kigamboni: in Dar es Salaam on Kenyatta Drive, on the opposite side of the Residence of the British Ambassador, there is a *mbuyu* tree with an official announcement on it, which forbids using this tree for witchcraft. As I was explained, the government had to put this sign on the tree due to the fact that people were constantly placing concoctions underneath and smearing its roots with chicken (presumably) blood. My informants noted, though, that the 'witchcraft business' (Sw.,

'*mambo ya uchawi*') was still going on but the bottles with medicines were moved to the other announcement-free side of the tree.

Treatment choices for *degedege*

Research on *degedege* shows that in most cases parents would resort to both biomedicine and traditional medicine (Comoro et al, 2003: 309; Dillip et al, 2012: 7; de Savigny et al, 2004: 3). Yet, Kamat argues (2008a: 68) that 'even though cultural knowledge and etiological beliefs about *degedege* may be shared locally, there is significant variation in the therapeutic pathways that parents follow to deal with an actual episode of the illness'. As Langwick (2007: 94) argues, the treatment is normally chosen through practice: if anti-malarials fail and convulsions start, the parents usually think it is *degedege* and switch to traditional medicine; sometimes they are even referred to *waganga* by the hospital staff.

Literature raises the problem of tardiness in the treatment seeking practices of the parents who tend to address traditional healers first (cf. Comoro et al, 2003; de Savigny et al, 2004; Makemba et al, 1996; Nsimba & Kayombo, 2008; Dillip et al, 2012). This reluctance to go to hospitals at the early stage is usually explained as superstition about *degedege*, which needs to be eliminated through education (cf. de Savigny et al, 2004: 1; Dillip et al, 2012: 2). Stacey Langwick (2007: 95) interviewed the coordinator of the National Malaria Control Program for the Tanzanian Ministry of Health Dr. Mwita, who had this to say:

[Our goal is to] enlighten people on malaria so that the people can discover the symptoms. They can realize that malaria is treatable. They can take their children with fever [to a clinic]. They can know what convulsions are, that those are no evil spirits (Interview, 19 April 2000).

While acknowledging the importance of education, some authors overlook the deeper reasons behind the treatment decision-making, which favors traditional medicine as the first resort in the case of *degedege*. It is not even suggested that traditional medicines might be more efficacious than biomedical for this condition. Most of my informants said that *degedege* could be cured successfully by *waganga* (in contrast to *kifafa*, which was seen as incurable). Interestingly, all the traditional healers I interviewed said that they treated *kifafa* and *degedege* with the same medicines. This was also confirmed by some people with *kifafa* I spoke with, the 23-year-old Mohamed Salum in particular.

The usual treatment pattern of *degedege* is bringing the child to a healer to alleviate the condition; once it's done and the convulsions have subsided, the child is brought to hospital for further

treatment (de Savigny et al, 2004: 7; Comoro et al, 2003: 309). The simultaneous manifestation of the fever and twitching symptoms is usually interpreted as *degedege*, while fever alone is more likely to be taken as malaria and treated biomedically. When the child starts convulsing, the first reaction of many mothers is to rush him/her to the latrine (Sw., '*choo*'). There the child would be laid on a banana leaf and washed with the mother's urine. The smell of the urine as well as the smell of the latrine itself is believed to repel the spirit of *degedege* and, thus, to stop convulsions (Kamat, 2008a: 73). Subsequently, the child is taken to a healer, who usually treats the patient with medicinal baths or uses divination (Sw., '*ramli*') to determine the treatment (Ibid.). Along with bathing, *degedege* patients are fumed with elephant dung¹³, given herbal concoctions to drink and some amulets to wear. All these therapies are perceived as the first stage of treatment, which is aimed at 'cooling the illness down' and preventing convulsions (Makemba et al, 1996: 310). Some researchers contradict this treatment pattern and argue that the majority of caregivers would take their children to a biomedical institution as their first choice even in the case of convulsions (de Savigny et al, 2004: 13; Kamat, 2008a: 75). It must be noted though that 'these statistical trends indicate what people would do in hypothetical situations, and not necessarily what they really do in "real-life" situations when they have to deal with an actual episode of *degedege*' (Kamat, 2008a: 75).

Once *degedege* is 'cooled down' and the child is no longer running the risk of dying, the parents may decide to either continue treatment with the *mganga* or go to a hospital. Most parents shape the treatment by first addressing the healers and then the doctors (cf. de Savigny et al, 2004; Comoro et al, 2003; Langwick, 2007; Dillip et al, 2012). Sometimes it is perceived more efficacious to make use of both the healing domains simultaneously: Langwick for example witnessed that almost all hospital patients diagnosed with febrile convulsions were wearing amulets made by *waganga* (Langwick, 2007: 96). The reasons behind this treatment behavior are not only etiological; they are related to various factors like financial issues, proximity of the healthcare point, convenience, efficacy of the provided treatment, pressure from the influential community members (cf. Comoro et al, 2003: 309-310), and even random chance (cf. Kamat, 2008a).

In the literature on *degedege* we read that one of the main reasons for not taking the child to a biomedical facility is the fear of injections (Kamat, 2008a; Makemba et al, 1996; Winch et al, 1996; Langwick, 2007). A number of my informants supported the idea that puncturing the skin would make the child more susceptible to malevolent spirits and enable them to enter the body causing rapid death. Kamat's research however shows that 'there is an overwhelming preference among the local people to treat malaria and several other childhood conditions with injections because of their

¹³ It is done by taking the dung and putting it into the fire. The patients must inhale the fume for the therapeutic effect.

dramatic effects' (2008a: 75). This statement takes for granted the parity between 'biomedical' malaria and 'traditional' *degedege*, which are not necessarily identical; rather they are distinguished from one another through treatment practice (cf. Langwick, 2007). If a child doesn't respond to hospital medicine, he or she may have *degedege*; in this case even doctors may refer the patient to a traditional healer (Ibid.: 94).

The question of efficacy is also in play when it comes to treatment decision-making. One of Dillip et al's (Dillip et al, 2012: 7) informants explains why she switched to traditional healing from hospital drugs:

We have been to the hospital more than three times for convulsions this year. I think their medicines are not working. This time, I chose to go straight to the traditional healer, and my child is doing fine now (Mother aged 18 from Indunda village, 2007/2008).

Empirical efficacy of traditional treatment is acknowledged in the literature (Makemba et al, 1996: 311) but often attributed to 'nosological fusion' between severe malaria and febrile convulsions. According to Makemba et al, the latter is not fatal and easily cured by lowering the body temperature. Thus, healers 'intervene and take credit for cases that would have resolved spontaneously' (Ibid.). Low success rate of the hospitals in treating *degedege* is explained by significant delay on the part of the parents due to transportation difficulties and financial hardship (Ibid.: 312). In order to probe deeper into the reasons behind particular treatment choices of the parents whose children have *degedege*, I shall address three cases of this condition. I stress once again that all the healers I interviewed said that they used very similar (often the same) medication for their patients with *kifafa* and with *degedege*.

Case studies of *degedege*

Case 1. Aifa Mfaume

Mzee Ally Mzee, a 64-year-old *mganga*, was showing me and Shabani around his compound. While I was taking pictures of the room where he accepted his patients and asking him the usual polite questions before starting an actual interview, a middle-aged woman with a suckling interrupted us with a decisive '*Hodi!*' (Sw., 'May I come in?'). After Mzee Ally Mzee's '*Karibu*' (Sw., 'Welcome') she entered and explained that her 3-month-old child was burning up and convulsing. The traditional healer quickly examined little Aifa and said that she probably had *degedege*. Interested in what happens next, I asked my interviewee to let me watch him work and talk with the worried mother.

Hadija Mfaume, the mother of Aifa, said that it wasn't the first time that her daughter had fever, was shivering, twitching and her eyes were white. When Hadija first recognized these symptoms, she rushed her child to a private doctor whose name was Shiba. Aifa was diagnosed with malaria and given three injections, after which she got better. Yet, after some time the fever returned. This time Hadija preferred to go to Mzee Ally Mzee for treatment; the healer was also distantly related to her. When I asked the mother why she switched treatment, she said that the medicines administered by the private practitioner were not efficacious, so as a result, Aifa got sick again. That's why Hadija decided to try her relative's healing method.

I asked Mzee Ally Mzee how he usually went about treating *degedege*. He said that he first examined the patient to make sure the diagnosis was right; in case of doubt he resorted to divination (*ramli*). Once, the diagnosis was determined, the healer usually used the following herbs to treat *degedege* (he said that he used the same herbs for *kifafa*, also those that were supposed to fight high fever):

- *Mzalianyuma* (Sw., 'spurge'). This plant is crushed and used for making a drinking concoction. Different varieties of spurge are also used for treating gonorrhoea.
- *Kivumbasi* (Sw., 'lemon basil'), *mtimkuu*, and *mbonokaburi* (Sw., 'Barbados nut' or *Jatropha curcas*) are mixed and boiled. The patient is bathed in the medicinal water. Mzee Ally Mzee said that the bathing reduced the body temperature.
- *Mavi ya tembo* (Sw., 'elephant dung') was fumed on the patient to chase the evil coastal spirit of *degedege* away.

Mzee Ally Mzee uses Quran for divination; he is also guided by the two spirits or genies (Sw., '*majini*') inherited by him from his teacher. Unfortunately, the outcome of Aifa's treatment is unknown as I never had the chance of revisiting Mzee Ally Mzee.

Case 2. Ali Pokoto

I was referred to Ali Pokoto's mother by her neighbor, who heard that I was interested in *kifafa*. Shabani and I were on our way to Saidi, Johnny's friend who had *kifafa*, when my research assistant ran into an acquaintance, who got curious about me and my research. Eager to help, Shabani's friend informed us that he knew a woman, whose son had *kifafa*. The mother of the boy lived not far from Saidi, so we decided to interview her on our way back from him.

It was about 11 a.m. when we reached the house of Kishtobe Pokoto. There were about six women sitting or lying on a large *mkeka* (Sw., 'mat') in the shade of a mango tree next to the house. They all appeared to be in good mood, already tipsy on *konyagi* (a rather strong Tanzanian alcoholic beverage). They invited us to be seated and join them in their libation, which we politely declined. I

asked Kishtobe to go and seat somewhere aside from her guests so that we could talk in a more private atmosphere. I started the interview by asking her to tell me about her child's condition and the treatment she was using.

Ali Pokoto was three and had *degedege*, according to his mother. I was surprised to see the child running around and looking completely healthy, so I asked Kishtobe when she found out that Ali had *degedege*. She said that Ali was around two when she learned that her child had it. The boy convulsed and had seizures, during which he lost consciousness, but he never had fever. Kishtobe then took him to Ibla, one of the local traditional healers I interviewed. Ibla said that Ali's *degedege* was caused by malevolent spirits (*mashetani*) and treated him with medicinal baths and herbal concoctions. Subsequently, the child recovered, but a couple of months before the interview he started having seizures:

I was very happy with Ibla's work because my child felt well and stopped twitching. But a couple of months ago he fell (*alianguka*) and convulsed, he was completely unconscious (*alipoteza akili*). The seizure repeated the second time in a couple of weeks. Once I have enough money I will go to Ibla again. I think this time somebody bewitched my child, because the healer had chased *mashetani* away when he treated *degedege* (From the interview with Kishtobe Pokoto on June 27, 2012).



Kishtobe Pokoto and her son Ali

Kishtobe paid 5000 Tanzanian shillings (about 2,5 euros) to Ibla when he cured Ali. This is a substantial sum of money for an average Kigamboni resident. Yet, the woman was willing to spend it again to bring Ali to the same healer, who she hoped was able to help her son. According to de Savigny et al (2004: 2), the treatment is free for children under five years of age in governmental health facilities in Tanzania. Thus, it appears that it would have been more sensible to go to a local dispensary and seek treatment there. It was evident that Kishtobe's income was even below the income average of Kigamboni residents, but she chose the treatment pattern, which was more expensive. The woman explained that she was afraid of injections, that's why she didn't even consider the option of taking Ali to a biomedical facility. Injections were fatal in the case of *degedege*, so she went to Ibla for help.

Case 3. Hakam Hatib

After a long research day I was about to go back home to the Russian-Tanzanian Cultural Centre. I stopped at a small shop (Sw., 'duka') to buy some water and rest for a while. As usual, my Swahili and the purpose of my stay in Tanzania caused vivid interest and resulted in a friendly conversation. Fatuma, the saleswoman, told me that I should talk to her neighbor Johari, whose son had *kifafa*. I said that I would return the next day and interview her. I asked Fatuma if she could bring Johari to the shop at nine o'clock in the morning so that she wouldn't have to leave her *duka* to show me where Johari lived. Fatuma agreed and I left shortly afterwards.



Johari and her sons Hakam and Yusufu

At nine o'clock I entered Fatuma's shop and greeted everyone inside. Johari came with her two sons, Hakam and Yusufu. I asked Johari which of her sons had *kifafa*. She answered it was Hakam but she wasn't completely sure if he had *kifafa* or *degedege*. Hakam Hatib was four and he first started twitching when he was one and a half. Johari then took him to the local dispensary on the second day from the moment the fever and convulsions appeared. Johari explained that she first tried sponging the child to bring the temperature down and went to the hospital after she failed. At the dispensary Hakam was diagnosed with malaria and given chloroquine injections. The child got better but in a year the symptoms returned, which led Johari to think that it wasn't malaria after all. Once again she took Hakam to the dispensary, where he again was diagnosed with malaria:

They didn't even take a blood sample for analysis at the dispensary, but said it was malaria. My son was frothing at the mouth and had trouble breathing. They prescribed Panadol [an antipyretic] but it didn't help Hakam. I didn't think the diagnosis was right, so I asked them to refer me to Muhimbili. I took my son there; the doctor said that an X-ray was to be done. It was too expensive for me, so I didn't go through with it and left. When I have enough money, I'll come back (From the interview with Johari Hatib on July 1, 2012).

Johari also confessed that she was worried about Yusufu as well because a couple of months before he also had high fever, his eyes were white and the right side of his body was twitching. Like his brother, Yusufu was prescribed anti-malarial injections at the Kigamboni hospital and got better. Johari was very confused about the condition(s) of her sons. She was unsure whether they both had the same condition or different ones, whether it was *kifafa*, *degedege*, malaria or something else. She said that Hakam had seizures once a year and she was afraid that Yusufu would end up like her elder boy after going through the same treatment path as his brother. She doesn't know if this condition is contagious either. When asked how she would proceed with treatment seeking, Johari said she would try to gather enough money for the X-ray. If biomedicine fails to treat Hakam, she would address a traditional healer.

Interpretation of the cases

In the first case of Aifa Mfaume the mother took her child to a traditional healer after having tried the services of a private biomedical practitioner and being unhappy with the outcome. Mzee Ally Mzee was the second choice of the worried mother also because he was Hadija's distant relative, whom she obviously trusted more than any other *mganga*. The mother's decision-making was determined by the perceived efficacy of the treatment rather than financial concerns. Otherwise, she wouldn't have rushed her daughter to an expensive private doctor, who prescribed injections. The mother also wasn't afraid that puncturing the skin of her child would have dramatic effect on Aifa; when she addressed Dr. Shiba she was convinced that biomedicine and injections would be efficacious. Hadija acknowledged that the chloroquine shots worked, but soon Aifa's affliction

returned. It was then that the mother realized that Dr. Shiba's treatment was not efficacious. Subsequently, the dissatisfaction with the biomedical treatment led Hadija to Mzee Ally Mzee. Hadija wasn't confused by the diagnosis of *degedege*, she thought it was right. The problem was in the biomedical treatment, so she switched to a traditional healer.

The second case of Ali Pokoto is more confusing than the previous one. Kishtobe's neighbor referred me to her believing that her son had *kifafa*. The mother herself was sure that Ali had *degedege*. She said that her child didn't have fever but he was twitching, so she took him to a healer. Ibla, the *mganga* who treated Ali, said that the boy had *degedege*. The cause of the condition was attributed to *mashetani*, which Ibla chased away with baths and medicines. Kishtobe then paid him a substantial sum of 5000 Tsh (Tanzanian shillings) and was happy with the treatment outcome – Ali was cured. When the symptoms returned, Kishtobe didn't doubt Ibla's treatment efficacy, but she interpreted Ali's condition as a work of a witch. Due to this etiology explanation, the mother said she would go to Ibla again as soon as she had enough money.

Unlike the mother of Aifa, Ali's mother was obviously concerned with the financial issues involved in the treatment decision-making. Yet, she didn't rush her son to the local dispensary, which provided free services for children less than five years of age. It means that Kishtobe's perceptions of Ali's condition led her to consider traditional medicine as the only option. Afraid that hospital injections could be fatal for her child, Kishtobe sought help at *mganga's* compound. She was satisfied with the healer's diagnosis and treatment methods also due to the fact that her own interpretations of her son's condition corresponded with Ibla's explanation. Despite the return of '*degedege*', the mother didn't attribute it to the healer's treatment being inefficient. On the contrary, she said that she would go to Ibla again, this time to fight the *mchawi*. Where Aifa's mother would probably switch treatment, Ali's mother would stick to the same healer.

As for Ibla's diagnosis, it is difficult to say whether it was correct or not. Most my informants insisted on *degedege* being febrile; Ali didn't have fever but was diagnosed with *degedege* anyway. Shabani's friend who referred me to Kishtobe was sure that her son had *kifafa*. The symptoms described by the mother of the child indeed are more likely to be associated with *kifafa* than with *degedege*. At the same time, both conditions are very similar in terms of the symptoms (except *degedege* being characterized by high fever) and can be easily confused with one another. It also might be that Ali had *degedege*, which later on evolved into *kifafa* or vice versa.

Johari Hatib was unsure how to interpret her elder son Hakam's condition. When he first started twitching and had high fever, she took him to the local dispensary, where the boy was diagnosed with malaria and given chloroquine injections. Johari wasn't afraid of the shots and trusted the

doctors; moreover, Hakam got better. In a year the child started convulsing again, which for Johari was a sign of the wrong diagnosis made by the biomedical doctors. Despite her doubts, she took Hakam to the same dispensary again. The doctor there said the child had malaria without even taking a blood sample. The worried mother then asked for a referral to Muhimbili National Hospital in Dar es Salaam. At Muhimbili the doctor said that an X-ray was to be done, but Johari didn't have enough money for the procedure. She left, but was determined to come back and go through with the X-ray as soon as she gathered enough money for it. The mother considered addressing a traditional healer only as her last resort if the hospital treatment failed.

Johari was confused and worried because her younger son Yusufu seemed to have the same condition or conditions as Hakam. Yet, she didn't try to change the treatment pattern she used for the elder boy. From the three cases I presented here, Johari was somewhere in the middle in terms of her social and financial standing. Hadija was the highest in this hierarchy and Kishtobe was the lowest. Hadija was the only one whose decisions were based on the perceived efficacy of the treatment: dissatisfied with the services of a private practitioner, she switched to traditional medicine. Kishtobe and Johari were firm in their beliefs about where and how their children should be treated. The former was confident about traditional medicine and stuck to it despite the return of Ali's *degedege*. The latter persistently brought her children to the same local dispensary in spite of explicit confusion and doubt that the diagnosis made by the hospital doctors was correct. Thus, Kishtobe was inclined to choose traditional medicine no matter what, Johari – biomedicine, and Hadija – efficacy. Of course, it is not to say that if the circumstances were to change these three mothers would still follow the same pattern (cf. Kamat, 2008a: 68).

In the third case *degedege* appears along with *kifafa* and malaria. All these three afflictions are considered possible to define Hakam's condition. Johari herself has doubts about the biomedical conclusion that her son has malaria; this diagnosis seems even more dubious due to the fact that the doctors from the dispensary didn't take a blood sample from the child for analysis. In literature (de Savigny et al, 2004; Comoro et al, 2003; Langwick, 2007; Dillip et al, 2012; Nsimba & Kayombo, 2008; Makemba et al, 1996) *degedege* is always paired with its biomedical doppelganger malaria; my respondents were not always sure about this correlation, though. Rather, *degedege* was always mentioned together with *kifafa* and even confused with it. *Waganga* also confessed that there was little difference between those two, and that they usually used the same or very similar treatment for both. The only firm and universal belief was that *degedege* could only befall children up to 4-5 years of age. Otherwise, *degedege* was often referred to as '*kifafa cha utoto*'.

Conclusion

I've made an attempt to provide a better understanding of the relationship between *kifafa*, *degedege* and malaria. Most of my informants, including traditional healers, called *degedege* '*kifafa cha utoto*' (Sw., 'childhood epilepsy') and said that symptomatically the two conditions were very similar except for *kifafa* being non-febrile. The treatment used for *kifafa* and *degedege* by *waganga* was reported to be the same or very similar. The age range of *degedege* was something all the interviewees agreed on: up to 4-5 years of age. Having *degedege* as an adult was a sign of being bewitched, according to one of my informants. Otherwise, *degedege* is seen as childhood condition only. The literature, though, suggests that *degedege* may befall anyone, be it a child or a grown-up. In Kigamboni I met nobody who supported this claim.

The symptoms of *degedege* include the following: high fever, twitching, loss of appetite, stiffness of the body, white eyes, dehydration and frothing at the mouth. *Kifafa* manifests itself in a similar way but is usually described as a non-febrile condition. Thus, the two conditions can be easily confused with one another by non-professionals. As for etiology, *degedege* is attributed to the spirit bird (or *shetani*), *uchawi*, malaria, *kuvunja mwiko* (in this case failure to abstain from sex), and *mazingira* (here mostly related to the places where mosquitoes breed) in the literature. During my research I came across only three interpretations of the causes of this condition: malaria, which correlates with the biomedical paradigm; then *mashetani* and *uchawi*, which are perceived as traditional. *Kifafa* is related to *degedege* etiologically; first of all, the latter is perceived as one of the causes of the former; secondly, *degedege* is explained through *kifafa*: this condition is referred to as '*kifafa cha utoto*'.

The literature doesn't focus on this etiological relationship between the two conditions; even epilepsy is only mentioned a couple of times as having similar symptoms. Malaria is on the contrary always present in the literature on *degedege*, sometimes seen as the cause of this condition, sometimes referred to as its biomedical doppelganger, but always paired with it and even identified through it. Most scholars tend to take this complex relationship between the two conditions for granted and call *degedege* 'severe/cerebral malaria' or 'malaria-induced febrile convulsions'. For the residents of Kigamboni, though, this correlation between malaria and *degedege* is not so evident. Even those who think that *degedege* is caused by malaria are not always eager to treat this condition at the hospital, while they are fine with treating malaria there.

Furthermore, despite the symptomatic similarity of *degedege* and *kifafa* we don't read that the former condition is stigmatizing in the academic publications. This is due to malaria being associated

with *degedege* and seen as not related to stigma by pro-biomedical institutions. *Kifafa* is on the contrary identified with epilepsy and labeled as stigmatizing. I argue that neither of these conditions causes stigma and discrimination; rather stigma is a construct built around *kifafa* in order to raise funds and awareness for fighting it.

Kifafa and *degedege* are very close etiologically, though the latter is characterized by more various explanations. Just like in the case of *kifafa*, the healing epistemology is very flexible and open about all the causal interpretations of *degedege*. If malaria allows for only one cause, *degedege* makes room for a number of etiological explanations. The difference in the 'age range' between *kifafa* and *degedege* doesn't influence the public opinion about the conditions: none of them is perceived as shameful, pejorative or stigmatizing.

Kifafa is often characterized as incurable, while *degedege* can be successfully cured by *waganga*. According to the literature, most caregivers use traditional and biomedical methods simultaneously to treat *degedege*. The reasons behind this treatment behavior are not only etiological; they are related to various factors like financial issues, proximity of the healthcare point, convenience, efficacy of the provided treatment, pressure from the influential community members, and even random chance.

Many parents are reluctant to take their children to hospitals in case of *degedege* because of the fear of injections. This idea is widespread in the literature and is also confirmed by my informants. It is believed that puncturing the skin with a needle can be fatal for the child with *degedege*, as the malevolent spirit penetrates the body through the punctured skin. Due to this fear many parents prefer traditional treatment with medicinal baths, amulets, fuming with elephant dung, and drinking of herbal concoctions.

The matter of efficacy is a very important factor in treatment decision-making. Many caregivers are dissatisfied with the services of the biomedical practitioners and address traditional healers. The efficacy of traditional treatment is acknowledged in the literature but downplayed and explained by 'nosological fusion' between severe malaria and febrile convulsions. Some scholars argue that the latter is not fatal and easily cured by lowering the body temperature. Thus, according to these authors, healers intervene and take credit for cases that would have resolved spontaneously. Low success rate of the hospitals in treating *degedege* is explained by significant delay on the part of the parents due to transportation difficulties and financial hardship.

I represented three cases of *degedege* in this chapter in order to show how caregivers make their treatment decisions and what kind of reasoning is behind them. In the first case Aifa's mother could

afford whatever healing practitioner she wanted; her main concern was with the efficacy of the treatment. That's why she switched from an expensive private doctor to her distant relative *mganga* Mzee Ally Mzee. The mother of little Ali Pokoto was the poorest of the three mothers, whose children were represented in the cases. Despite financial difficulties, she chose to go to a traditional healer and paid him a substantial sum. Furthermore, Kishtobe said she would address the same *mganga* again after Ali's condition returned. The mother believed Ibla's treatment to be efficacious, though her son started convulsing again. She also feared injections. Thus, Kishtobe was driven by the perceived etiology of Ali's condition rather than the treatment efficacy. Financial issues were in play as well, but they were less important than etiological concerns.

Johari Hatib was in the middle of the income hierarchy of the three cases. Her treatment decision-making was shaped by her belief in biomedicine: she persistently took her sons to the hospitals in spite of being dissatisfied with the diagnoses and treatment outcomes. Johari said she would consider addressing a healer only after exhausting all biomedical treatment opportunities. Thus, Kishtobe was inclined to opt for traditional medicine no matter what, Johari – for biomedicine, and Hadija – for efficacy. Of course, it is not to say that if the circumstances were to change these three mothers would still follow the same pattern (cf. Kamat, 2008a: 68).

Degegede and *kifafa* are not only etiologically intertwined and sometimes explained through and confused with one another, they are also often treated in a very similar way by *waganga*. This is not surprising given that the symptoms of the two conditions are almost the same, except the fever in the case of *degegede*. *Kifafa* is more etiologically confusing and obscure for the informants than *degegede*; there are multiple explanations of its cause, while '*kifafa cha utoto*' is attributed to *uchawi*, malaria or *mashetani* by the residents of Kigamboni. *Kifafa* is also considered to be incurable in contrast with *degegede*, which can be completely cured.

Now it is important to look at the treatment choices made by people with *kifafa* and see how (if) they differ from the treatment patterns in the cases of *degegede*. This will be done in the following chapter.

Chapter 4. Treatment choices

In the previous chapters I looked at the causes of *kifafa* and analyzed the condition called ‘*degedege*’. In the present chapter I will address the treatment decision-making of the people with *kifafa* and their caregivers and analyze the answers of the semi-structured survey participants, who were asked to anticipate that they had *kifafa* and to think of their ‘would-be’ first treatment choice (biomedicine or traditional medicine). I will also devote a section to the healers I interviewed and give room to their treatment methods. An interview with Dr. Sayan Saleh from Muhimbili National Hospital will also help to understand the treatment choices better. Information related to treatment choices gathered in the course of the interviews with the people who have *kifafa* and their caregivers will also be included in this chapter.

Semi-structured survey participants

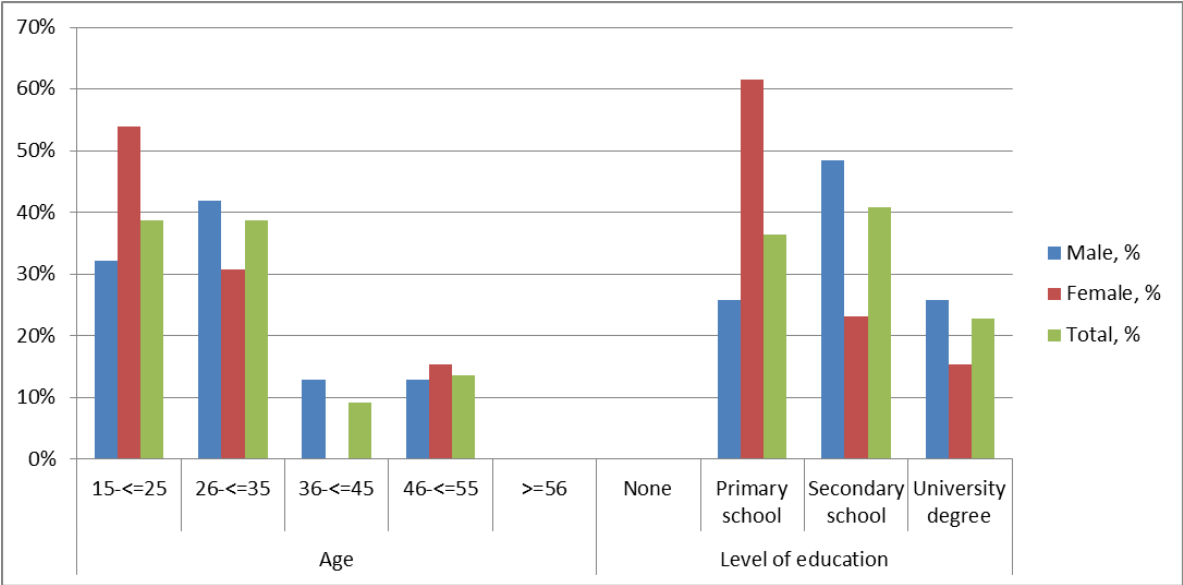
In this section I will present the data related to treatment choices, gathered through the semi-structured survey. As I mentioned before, the survey participants were not directly affected by *kifafa* and were asked to anticipate a situation in which they or their close relatives had this condition. Then the informants were to think of a certain treatment pattern they would follow as their first resort. It must be stressed here that anticipated treatment decisions are not necessarily those that would be taken if the survey participants were to face *kifafa* in reality. Given multiple explanations of this condition that were represented in Chapter 2, it is very hard to fully rely on the survey data in terms of defining a clear and consistent treatment decision-making strategy.

The survey participants almost always had multiple explanations of *kifafa*, sometimes biomedical (like *kurithi* for example) and traditional in nature (like *uchawi* or *mashetani*) simultaneously. Thus, *kifafa* is not perceived as a ‘disease’, which has a strong connotation of a defined bodily condition, but rather as a state that is unique for every person affected by it; this, in turn, allows for a very wide scope of etiological interpretations. It appears that there are no strictly defined causes of the condition called ‘*kifafa*’, nothing is labeled as ‘right’ or ‘wrong’; not a single interpretation is dismissed, all explanations co-exist in the field of uncertainty around *kifafa*. The adoption of every interpretation available without antagonizing the perceptions, which are inherently different (it might seem), is part of the healing epistemology in Kigamboni. Quite astonishingly, it is uncertainty that is a norm for the medical habitus of Kigamboni and it is this very uncertainty (or etiological pluralism) that makes the habitus work and reproduce itself. Keeping all this in mind, I will present

the first resort treatment choices of the survey participants and try to see if (and how) they are influenced by gender, age, education and the perceived etiology of *kifafa*.

Biomedicine as first resort

Biomedicine was suggested as the first choice treatment option by 42% of all the survey participants, which includes 32% of all the females and 48% of all men. Thus, male informants are more positive about hospital treatment than female ones. Graph 13 visualizes how all these informants are distributed by age, gender and education level. As we see, biomedicine is more popular with the youngest women, with the popularity decreasing as the age grows; no females from the third and the fifth age groups would choose a biomedical facility as their first resort. As for men, most of those who said they would prefer to go to a doctor if affected by *kifafa* are found in the second age group, which is not surprising as the majority of male survey participants belongs to this group. Both for women and men, biomedicine is more popular with the youngest generation. All men and all women with a university degree would go to a doctor as their first choice; most men with secondary education would do the same. Most women, who said they favored biomedicine more than traditional medicine, have primary education, which is also due to female survey participants being less educated than male informants in general.



Graph 13. Gender, age and education level of the survey participants, who would prefer biomedicine (%)

Thus, biomedicine is more likely to be chosen as the first resort by young males with high education level (secondary and above) and by people with university degree in general. Women and people of older age are less inclined to choose biomedicine than young men. It could be explained by the influence of biomedical discourse on the healthcare system of Tanzania, which has grown after the

1990s, affecting people of young age. Education is also a very influential factor in the treatment decision-making: biomedicine is more trusted by people with secondary and higher education. Gender also plays its part in the field of treatment choices: male informants are usually better educated and more favorable of biomedicine both in terms of *kifafa's* etiology and its treatment than females. As men are usually considered providers for the family, they are under pressure to get better education to be able to support the household, while women are usually encouraged to be housewives or/and often engage in small trading businesses, which do not demand secondary or higher education.

Most of the survey participants (59%) who said they would prefer biomedical facilities as their first choice in case of *kifafa*, thought that this condition was hereditary (*kurithi*). *Ubongo* (brain) was a bit less popular with 57% of the informants, followed by *kichwa* (head) and *kuzaliwa nao* (inborn condition) with 34%, *uchawi* with 27% and *degedege* with 25% of the respondents. The most popular interpretations were related to bodily causes (*kichwa, ubongo, kurithi*), which is not surprising given that biomedicine provides the same etiology of epilepsy. Yet, witchcraft is not dismissed as a possible explanation even if biomedical treatment is preferred. It again proves the plurality of ideas around *kifafa*, which allows for both cold biomedical rationality and firm belief in supernatural powers.

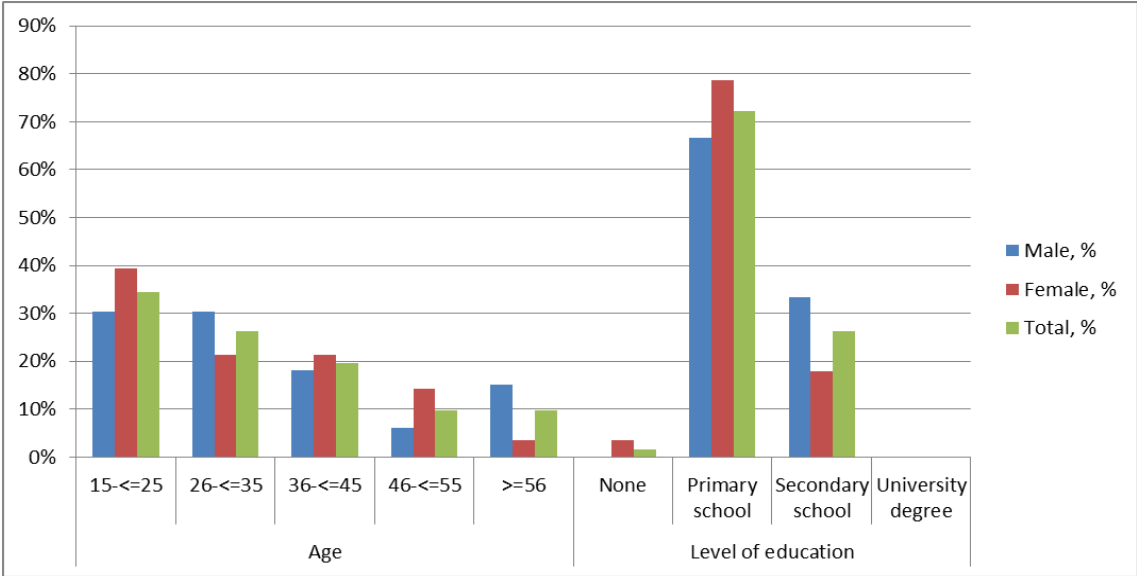
As we see, treatment choices are often very much influenced by the etiological explanations of a particular condition and by the discourses introduced by various institutions (education, biomedicine, traditional medicine, the government, NGOs, etc.), though are not necessarily defined solely by the perceived causes. It again must be stressed that the survey participants were not directly affected by *kifafa* and did not have a chance of putting their ideas to test within the practice of treatment. That is why it is important to compare the treatment preferences of the survey participants with those of people who have *kifafa* and who have actually experienced various treatments, which will be done further in this chapter.

Traditional medicine as first resort

Traditional medicine was stated as the first choice treatment for *kifafa* by the majority of the respondents: 58% of them said they would prefer the services of *waganga*. Women were more favorable towards traditional medicine than men: 68% of all females said they would go to a healer as their first resort. Men supporting this treatment pattern were fewer (52%) but nevertheless comprised more than a half of all the male respondents. Graph 14 shows that younger people are more inclined to address a traditional healer in the case of *kifafa*. This could be attributed to the quantitative prevalence of the youth in the survey sample in general. Quite contrary to Graph 13, which represents how the participants who would prefer biomedicine were distributed by age, Graph

14 visualizes that many people from the third, the fourth and the fifth age groups would choose traditional medicine as their first resort. Thus, traditional medicine as the first treatment choice is more popular with the older people than biomedicine.

The education level proves to be influential in treatment decision-making for *kifafa*. Most survey participants, who said they would address *waganga* for this condition, have primary education. Not a single person with a university degree was supportive of this treatment pattern. This outcome is not surprising as the education system in Tanzania is very pro-Western and also pro-biomedical. People of younger age as well as those who belong to the fourth and fifth age groups usually have primary education. Primary education is given in Swahili while secondary is usually administered in English. Social standing and education are very tightly intertwined: the better-off the family, the higher the level of education of their children. As we established before, biomedical etiology of *kifafa* is often a product that people get with a university degree.



Graph 14. Gender, age and education level of the survey participants, who said they would prefer traditional medicine (%)

Uchawi was the most popular etiological explanation of *kifafa* (84% of the participants, who stated traditional medicine as their preferred treatment) to be addressed with traditional medicine. It was followed by *kuzaliwa nao* with 59%, *tumbo* with 33%, *kichwa* with 28% and *degedege* with 23% of the respondents. Interestingly, all the informants who suggested the *majini/mashetani* explanation of *kifafa* said they would go to a healer as their first resort. As we remember, *degedege* is also often attributed to *mashetani* and traditional treatment is preferred. As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine prefer

supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*).

Even physical explanations like *tumbo* and *degedege* are very much related to the etiology suggested by *waganga*. *Tumbo*, for example, is thought to be the place from where *mashetani* climb up to the head (*kichwa*) causing a seizure. The *kichwa* interpretation is related to biomedicine, yet it already has been incorporated into the traditional etiology of *kifafa*, largely promoted by *waganga*. Once again we see ideas travelling from one medical domain to another; nothing is clearly defined, all the interpretations are intertwined and considered valid and possible. The epistemology of healing in Kigamboni appears to allow for every explanation, while the Western one does its work through excluding particular interpretations in search of a clear-cut solution. To probe deeper into the treatment decision-making in the case of *kifafa*, I shall represent four case studies of the treatments offered by *waganga*.

Traditional healers and their treatments

I interviewed five local *waganga* of Kigamboni but in this section I will only talk about four healers, as I already described the treatment usually used by Mzee Ally Mzee in the previous chapter. All the interviews were conducted in the healers' compounds without preliminary arrangements.

Case 1. Mzee Ibla

June was almost over and my fieldwork was well under way when I decided to talk to *waganga* and see how their opinions on the etiology of *kifafa* correlated with those of laypeople and of the residents of Kigamboni who had *kifafa*. I relied on Shabani to show me to the healers; he was also the one who chose which practitioners to visit. Our first destination was Mzee Ibla's compound; the house was next to the road and easily recognizable with a high sausage tree (*mwegea*) behind it. Ibla was home and willing to talk as there were no patients seeking his help at that time of the day. I explained the purpose of my stay in Tanzania and my research, and asked him if he was up for an interview, to which he agreed.

By the look of the compound, this healer was rather popular among the residents and even had a separate room for divination, which stood approximately ten meters away from the house where he lived. As Ibla told me, he was a Makonde (an ethnic group mostly found in South-Eastern Tanzania), but was born in Mjimwema. He started practicing healing twelve years before and got his gift from his grandmother, who was a powerful *mganga*. Before finding out that he was able to cure people he had a very severe illness, which almost killed him. Research has shown (cf. Ria Reis, 2000) that Carl

Jung's concept of the 'wounded healer' is indeed very useful as an analytical tool for understanding how *waganga* cross the border between life and death and obtain therapeutic powers. The concept suggests that the victory over a deadly condition makes it possible for healers to be mediators between the material and spiritual worlds.



Mzee Ibla's divination room¹⁴

Upon recovery, Ibla embraced his healing gift along with the four genies that helped him with the divination. Not only was he helped by these *majini*, but also by Quran; moreover, as Ibla assured me, his knowledge of the medicinal herbs was profound as well. Thus, the efficacy of his treatment was not only ensured but even somehow legitimized by his gift being passed to him from his grandmother, by recovering from a serious illness, by being possessed by four (not one and not even two) *majini*, by using Quran for divination and by being a herbalist at that. When Ibla proudly concluded his 'service record' saying that he specialized in all the conditions and could cure anything, it didn't come as a surprise.

¹⁴ All the pictures used here are taken by the author unless specified otherwise.

Mzee Ibla invited me to have a look at his divination room; it was full of concoctions, medicinal roots, amulets and Islamic posters. I noticed a placard with a creature that looked like a white Pegasus with a woman's face. I asked Ibla what it was and he said it was Buraki, a horse that helped him to perform divination. It was only when I came back home that I realized that the healer meant Buraq, a mystical horse that carried the Islamic Prophet Muhammad from Mecca to Jerusalem and back (The Qur'an 17:1). As Buraq transported Muhammad, it helped Mzee Ibla to see the invisible delivering him from the material world to the spiritual one and back. This Islamic horse was a means of crossing the border between the realm of spirits and the realm of people and getting therapeutic powers through it.

When I asked the healer how he usually treated *kifafa*, he said that in every case it was obligatory to use divination with Quran, for which he needed to know the patient's name. As for herbs, Ibla refused to disclose all the plants and roots he used for treating *kifafa*, but named only two – *mwaraka* (most likely it is *Ambygonocarpus angolensis*) and *kivumbasi* (lemon basil), already familiar to us from Mzee Ally Mzee's concoction ingredients.

Ibla claimed that he had cured five *kifafa* patients within the years of his practice. I was wondering if he only had five cases of *kifafa* or he had more but only was able to cure five, to which Mzee Ibla answered that he had more patients with *kifafa*, but they were unable to pay for his treatment and left. The price the healer demanded for his services was steep if not astronomical – 400 000 Tsh (about 191 €) before the full recovery. Seeing my surprised face, the healer added that the treatment was a long-term thing and could last for months. Ibla also said that he was flexible with his clients and allowed them to pay by installments. Nevertheless, the services of this particular *mganga* were beyond reach of most of the Kigamboni residents. On the other hand, it could also be that Mzee Ibla secretly hoped that I myself or maybe my relative was looking for his treatment, which made him name the *mzungu* (Sw., 'European person') price instead of *bei nafuu* (Sw., 'cheap price'). At least we know from Kishtobe Pokoto that he asked 5000 Tsh for the treatment of *degedege*, which is much more realistic and affordable for the Kigamboni clientele.

Case 2. Asha Salum

It was the first of July when Shabani brought me to the house of a female *mganga*¹⁵ known as Bibi Asha. She obviously couldn't afford a separate divination room; her house looked very modest compared to Ibla's. Asha Salum didn't greet us with the usual hospitality, which I by that time had

¹⁵ I asked Shabani to take me to random healers of both the genders. He picked them himself according to the principle of popularity; thus, I interviewed the most popular practitioners (in the subjective opinion of my research assistant).

gotten used to in Kigamboni, but agreed to answer my questions after I had explained to her what my research was about. Bibi Asha had been practicing *uganga* since 1998 and received her therapeutic gift from her mother. She said she had had a memory loss, after which she acquired her healing powers. Along with being knowledgeable of medicinal herbs, she was also helped by benevolent spirits (*majini*) that she addressed during divination. Asha Salum was born in Kibada to a Zaramo (an ethnic group usually found in Dar es Salaam region of Tanzania) mother and a Maasai (an ethnic group usually found in the Northern part of Tanzania) father.

Bibi Asha's field of proficiency was in treating conditions related to fertility and childbirth (Sw., 'uzazi') and also to malevolent spirits or demons (Sw., 'mapepo'). She said that she had had two patients with *kifafa*, whom she had cured with herbs. Some of her medicinal concoctions were to be ingested and some were used for bathing the patients. Asha Salum thought that the cause of *kifafa* was sand in the stomach (*mchanga kwenye tumbo*), which resulted in the following symptoms: high fever (*homa kali*), twitching (*kutetemeka*), stomach upset (*shtuko la tumbo*), nausea (*kutapika*), and protruding eyes (*macho yanajitokeza*). She added that *degedege* could also cause *kifafa* and usually preceded the latter (*kwanza degedege baadaye kifafa*). Bibi Asha said that there was no big difference between the two conditions and that she treated them similarly with herbs.

Bibi Asha was confident that *kifafa* was contagious and one could get it from the contact with the body fluids like vomit (*matapishi*) and urine (*mkoji*), which correlated with her etiology of *kifafa* as being a problem of the stomach. The question about contagiousness was my last as I felt that I overstayed my welcome. When we left Bibi's house to talk with another *mganga*, Shabani said that he didn't like Asha at all, especially the way she looked at us with her 'poisonous eyes' (*macho yenye sumu*). I shared the sentiment and was happy to leave the house and the unwelcoming *mganga*.

Case 3. Mariam Kondo

From Asha Salum we moved to Kibugumo to interview another female *mganga* Mariam Kondo. She was a very dignified woman of respectable age, who had been treating people for more than twenty years. Mariam was born in Kibugumo and lived there all her life; her parents were both Zaramo. This *mganga* specialized in stomach problems, but could also treat *kifafa*. Bibi Mariam didn't mention that she was ever seriously ill and almost died; neither did she have a helping spirit. She said that she was an herbalist and got this knowledge from her mother. Thus, she didn't perform a divination and had no special room for receiving patients.

According to Mariam, *kifafa* was the same thing as *degedege*; the only difference was in age: *degedege* was a childhood condition prevalent among children up to two years of age, while *kifafa*

could befall anyone. The cause of *kifafa* was unknown to this *mganga*, but she thought that a twisted mind (*akili inapinduka*) was a possible reason. According to Mariam, *kifafa* was contagious through the inhaling of the digestive gases from the anus of the person with this condition or through *upepo* (Sw., 'wind'), as she called it.



Herbs used by Mariam Kondo to treat *kifafa* and the *mganga* herself

Bibi Mariam used herbal medicines to be ingested along with the medicinal baths. On the picture above we can see some of the herbs used for treating *kifafa*, which Mariam Kondo collected specially for me. She also gave me a list of roots and leaves that she used for making medicinal concoctions. Unfortunately, I couldn't find translations for all the plants, so I will just use the Swahili names here:

- The leaves of *mvuja*: to be ingested and to be used for bathing
- *Kirihani* (Sw., 'sweet basil')
- *Mdimu* (Sw., 'lime tree'): both the roots and the leaves
- *Vumbasi kubwa* (most likely some sort of mint)
- *Mavimavi* (most likely [elephant?] dung)
- *Mkundekunde* (Sw., 'legumes', 'Eared Senna' or *Senna Petersiana*)
- *Subili* (Sw., 'aloe')
- *Vumbasi dogo* (some sort of mint or basil)

Mariam said that she usually used the roots to make drinking medicines while the leaves were to be included into the medicines for bathing. This healer had had multiple patients with *kifafa* over the years and claimed she cured everyone. Mariam Kondo asked 50 000 Tsh (24 €) for a course of *kifafa* treatment. This price is high for an average resident of Kigamboni but more reasonable than Mzee

Ibla's for example. Still, gathering such sum of money is bound to be a hard task and a substantial financial burden for a family providing for a relative with *kifafa*.

Case 4. Siwatu Hija

The house of Siwatu Hija, the fifth and the last *mganga* I interviewed, was located in Mjimwema and looked like any other house in the vicinity. The hostess was in good mood and greeted us with a smile. She also agreed to answer my questions and show me her divination room. The room was within the living space of Siwatu's house, the walls were painted red; there were multiple placards of Islamic nature, a clock, two telephone numbers written on the wall, and a framed certificate proving Siwatu Hija's membership in The National Organization of Traditional Healers and Midwives in Tanzania (CHAWATIATA). A poster with Buraq was on the wall as well.

Siwatu was born in Mjimwema to a Maasai father and a Zaramo mother; she had been practicing healing for fifteen years. This *mganga* didn't get her therapeutic gift from anyone, but she was helped by a *jini*, who had set her upon the healing path after she had recovered from a very serious condition. The *jini* also tells her through the divination how to treat the patients. Siwatu specialized in fertility related conditions and spirit possession. She had five patients with *kifafa*, four of them she cured and one died in hospital after she referred the patient there.



Siwatu Hija in her red divination room

According to Bibi Siwatu, *kifafa* and *degedege* are the same, though *degedege* is found in children up to the age of four and *kifafa* can befall both children and adults. Both the conditions are caused by

some disorder in the head, to be more precise, in the brain (*ubongo*); some kind of pressure in *ubongo* results in a seizure. Medicinal baths and herbal concoctions have to be taken to cure *kifafa* and *degedege*. Bibi Siwatu also said that *kifafa* was contagious through *upepo*.

Biomedical approach and Dr. Sayan Saleh

In this section I will rely on the interview with Dr. Sayan Saleh from the Department of Psychiatry and Mental Health of Muhimbili National Hospital. I interviewed him in late July of 2012 after I had talked with the five *waganga* and some people with *kifafa*. When I approached Muhimbili, it had just stopped raining and the ground was covered with puddles. Patients were waiting by the entrance, some of them standing or sitting, some lying on the benches. A young man on crutches probably forced on him by polio was preaching very loudly about salvation and God's will. Nobody seemed to pay attention to him despite his obvious effort and thundering voice.

I entered the small booth where receptionists resided and asked them for guidance. Bibi Salme and bibi Hasna greeted me very cheerfully and after I had explained my research kindly escorted me to the chief medical officer. When I entered the Muhimbili building I felt like I had been transported to another world: the white walls and the doctors in white robes seemed to have as little to do with the people waiting outside and the agitated 'prophet' as a plastic bag with a flower. The gates of the hospital were the borderline between the liveliness and multiplicity of medical interpretations and the biomedical organized certainty. Having spent two months in Kigamboni, I felt like an alien within the walls of National Hospital despite being brought up in an exclusively biomedical discourse. Muhimbili looked just like any hospital in Russia or elsewhere, yet I was struck by the contrast between what I saw next to the gates and inside them.

The busy-looking woman I was introduced to turned out to be the chief of the hospital. Her office was the whiteness and the cleanness itself brought to perfection. I briefly explained my research to her and she started making calls on her cell phone to arrange a meeting with the epilepsy specialist for me. She was talking in a very hectic manner and very quickly as if in a rush, quite in contrast with the Kigamboni reflexivity and relaxed slowness. The Swahili proverb '*Polepole ndio mwendo*' (Sw., literally 'slowly is indeed the way' or rather 'slow and steady wins the race'), which was so appropriate for describing the atmosphere in Kigamboni, was completely out of context in Muhimbili.

Shortly, I was brought to the office doors of Dr. Sayan Saleh who kindly answered my questions, which I kept to the minimum due to the busyness of my interviewee. As usual, I was speaking Swahili

but Dr. Saleh answered in English for some reason, so I switched to English. First, I wanted to know if there were a lot of patients with *kifafa* who were under treatment in the National Hospital. Dr. Saleh said there were very few *kifafa* patients and that those who were there usually didn't come to the hospital to treat *kifafa* per se but to address body burns and other traumas related to this condition. Most patients were thus referred to the mental illnesses department by traumatologists and rheumatologists.

According to Dr. Sayan Saleh, *kifafa* is in many cases caused by *degedege* if the caregivers fail to go to a doctor on time. For him the age range of *kifafa* is from seven years and older, while *degedege* is a childhood condition that is found in children up to ten years of age. The tardiness in the treatment of *degedege* often results in a child getting *kifafa*; the condition can also be hereditary (*kurithi*), though. Symptomatically *kifafa* and *degedege* are very similar, but in the case of the latter the child suffers from high fever.

As for treatment choices, Dr. Saleh was convinced that they were influenced by the etiological beliefs of the patients and the availability of the medical services in the area. Thus, people from the cities usually go to hospitals, as they are available and easy to reach, while in the rural areas people prefer to address *waganga*, as biomedical facilities are often far away and difficult to get to. From those *kifafa* patients that they have in Muhimbili, 75-80% get much better and continue with their lives; the remaining 20-25% don't see any changes in their condition and thus turn to *waganga* for help. Those 20-25% of the patients also tend to think that they were bewitched.

The treatment choices of people with *kifafa*

In this section I will represent the treatment patterns of the people with *kifafa* by addressing three cases. I picked these three people because their stories cover the treatment decisions and the reasoning behind these decisions of more than ten people with this condition and their caregivers. Thus, the cases are representative of the treatment choices made by those who have *kifafa* in Kigamboni.

Case 1. Mohamed Salum

The 23-year-old Mohamed Salum was the first person with *kifafa* I interviewed. His mother, some neighbors and the praepostor of the area were also present and took part in the conversation. We were all sitting on a big *mkeka* in the shade listening to Mohamed's mother Suna talking. Mohamed had *degedege* when he was a child, which was cured by a local traditional healer. When I asked what *degedege* was, everyone who took part in the conversation agreed that it was *kifafa cha utoto*

(childhood *kifafa*). When Mohamed went to primary school he had his first seizure. Suna then rushed him to a *mganga*, who fumed her son with elephant dung, bathed in herbal decoctions that contained *kivumbasi* (a sort of basil) and gave him medicines to drink. For the first two months Mohamed didn't have seizures, but later on *kifafa* returned.

Disappointed with the low efficacy of the traditional healer's treatment, Suna decided to switch to biomedicine. For that purpose she went to the local dispensary and got a referral to Tumbi Special Hospital in Kibaha. Tumbi lies in about 70 kilometers from Kigamboni, which is much farther than Muhimbili. Suna said she didn't want to go to Muhimbili because there were too many people. The doctor in Kibaha told her that Mohamed's *kifafa* had been caused by malaria, which damaged his brain. Suna believed the doctor but added that Mohamed could have been bewitched by some neighbor envious of Suna's husband's carrier successes.

The doctor prescribed anticonvulsants (Storilat 200 mg and Phenobarbital) that, according to everyone, were to be provided for free by the law. Nevertheless, at the hospital's pharmacy Suna was told that there were no pills left and that she had to go to a commercial drugstore to buy the prescribed items. The mother spends 9000 Tsh (about 5€) per month to buy the anticonvulsants; the sum is substantial for Mohamed's family. Yet, they are willing to spend it as the medicines help Mohamed; he doesn't have seizures as long as he takes the drugs.

Case 2. Nema Mhina Kalulu

Peter Kalulu, the brother of the 26-year-old Nema, was the only person who took care of the young woman with *kifafa*. Their parents died a couple of years before and Peter decided to move closer to Dar es Salaam with Nema in hope for a better life. He became a carpenter in Mjimwema, worked hard but the clients were few and he barely could make both ends meet. Nema couldn't work due to her condition. *Kifafa* manifested itself when they still lived in Tanga; Nema was about six at that time. She had had malaria and *degedege* earlier, and the doctor of the local dispensary said that malaria caused *kifafa*. The condition also affected the girl's hearing and mind (Sw., '*akili*') to the point she couldn't study. The seizures were very frequent, sometimes three times a day.

The doctor prescribed Phenobarbital, which helped Nema a lot as long as she kept taking it. The family spent 500 Tsh (about 0.25€) per month on her medication. Peter continues following the anticonvulsant treatment pattern in Kigamboni and is satisfied with the outcome. When his mother was yet alive, she took Nema to a traditional healer in Tanga. The *mganga* said that *kifafa* was caused by *uchawi* and tried to treat it with herbs but failed. Peter himself says that people tend to go

to healers because it's cheaper than getting to a hospital and buying prescribed medicines. But he finds biomedical treatment more efficacious than traditional one, so he sticks with Phenobarbital.

Case 3. Mwarami Shiamte

When we came to talk to Mwarami for the first time he was at work, but his mother offered us to wait for him and agreed to be asked some questions. Maimuna's 19-year-old son had his first seizure when he was twelve; he never had *degedege*, though. The frequency of the seizures was two times per week and they were relatively light. Since then Mwarami had been to three traditional healers and had never addressed a biomedical facility. Both Mwarami, who indeed joined us a bit later, and his mother were sure that his *kifafa* was caused either by witchcraft or by *mashetani*. Thus, they thought it was useless to go to a doctor; moreover, the people with the same condition they knew or heard of didn't recover with the hospital treatment. Biomedicine was powerless against supernatural and malevolent forces.

The first two *waganga* that Mwarami and Maimuna went to couldn't help him – *kifafa* was suppressed for a while but came back again. The third healer was more successful – his treatment worked and Mwarami got better (*alipata nafuu*). The *mganga* gave Mwarami herbs to be ingested and didn't prescribe any baths. When Mwarami felt that a seizure was approaching (he usually had a headache before it happened), he took the healer's medicines and they prevented it. Yet, the *mganga* was a travelling one, and Mwarami was running out of the medicine (Sw., 'dawa'). When asked what he would do when there would be nothing left, Mwarami said he would wait for the healer to return because he trusted him. If the successful *mganga* didn't come back, he would go to another healer. Addressing a doctor was out of the question because the young man was certain he was bewitched.

Conclusion

Most people who are not directly affected by *kifafa* said they would prefer to address a healer as their first choice in case they or their relatives had this condition. Yet, 48% of the respondents would consider biomedicine as a more desirable option. Women were more positive about traditional medicine than men, as were people of older age and those with low education level. Biomedicine, on the contrary, was supported by every survey participant with a university degree, most men and most informants with secondary education.

Among those who preferred biomedicine as their first treatment resort, most respondents supported the biomedical etiology of *kifafa* and attributed this condition to bodily causes (*kichwa*, *ubongo*,

kurithi). Yet, witchcraft is not dismissed as a possible explanation even if biomedical treatment is preferred. It again proves the plurality of ideas around *kifafa*, which allows for both biomedical rationality and firm belief in supernatural powers. The biomedical etiology doesn't necessarily mean that there is no room for doubt and uncertainty in the form of other explanations (e.g. witchcraft and *majini*).

As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine prefer supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*). At the same time, biomedical ideas about the etiology of *kifafa* are not dismissed, they are too considered valid and possible. The inherently biomedical explanation *kichwa* has been incorporated into the traditional etiology of *kifafa*, largely promoted by *waganga*. Once again we see ideas travelling from one medical domain to another; nothing is clearly defined, all the interpretations are intertwined and accepted. The two medical domains are not antagonized, rather they are perceived as treatment options that could be used regardless of the etiological beliefs.

I have represented four case studies of the treatment techniques applied by the local traditional healers in Kigamboni. All of them used medicinal herbs to treat *kifafa*, though only one *mganga* (Mariam Kondo) was explicitly an herbalist. The others were using multiple healing methods including divination with Quran and genies; to prove their therapeutic abilities most healers attributed their knowledge to their ancestors, who had taught them how to treat people. Most *waganga* were 'wounded healers', which means that they got their gift through recovering from a deadly condition. Having recovered, they obtained the power to heal other people; usually *majini* or other supernatural patrons spoke to them and told them how to treat the patients.

It appears that the more 'regalia' a healer has, the better; being just an herbalist is not enough anymore. Mzee Ibla is the most successful *mganga* in Kigamboni, he asks for a very steep payment for his services and at the same time he is the one who has most *majini* and most 'moral power' to heal. Ibla inherited his gift, recovered from a deadly condition, had four helping genies, used Quran in divination and was an herbalist too. All these characteristics made him look legitimate as *mganga* and undoubtedly attracted customers.

Other *waganga* were less 'accomplished' in this respect but had other advantages like the membership in CHAWATIATA and Islamic posters on the walls. It was almost as if the divination rooms of the traditional healers were standardized with Buraq and Mecca placards and phone numbers on the walls, bottles with concoctions, amulets and mats with mosques painted on them. An image of how the reception room of a *mganga* should look is being constructed in Kigamboni as

much as the image of a hospital ward has been created within the biomedical domain. Once again, just as with the etiology of *kifafa*, the multiplicity is considered a good thing; the more possibilities and options used simultaneously, the better.

The very diagnostic method most healers used, the divination, allowed for a wide range of etiological and treatment variations. The only classical herbalist, Mariam Kondo, was also the only one to give a more or less full and definite list of herbs she used for treating *kifafa*. I was wondering if it wasn't due to her clear-cut treatment solution for a particular condition called '*kifafa*' that she seemed like the only *mganga* who was really knowledgeable to me. All the other healers with their rather incomprehensible and invisible divination didn't convince me that they could treat *kifafa*. Yet, they apparently convinced the residents of Kigamboni, whose medical habitus differs from my biomedical epistemology and looks not for the treatment of diseases but rather of conditions, which may all be called '*kifafa*' but be different in every particular case. Thus, my own preference towards Mariam Kondo's defined treatment adds to my argument about the value of uncertainty and room for interpretation in the treatment decision-making for *kifafa* in Kigamboni.

Getting a biomedical treatment for *kifafa* is a completely different experience than addressing a healer. Muhimbili National Hospital as an institution and as a building represents a border between discourses, which is nevertheless frequently crossed. The very whiteness, cleanness, decoration minimalism and hurriedness of the employees demonstrate the difference in the approaches towards treatment in biomedicine and traditional medicine. Even the language used is not the one spoken outside the hospital doors: here English is preferred rather than Swahili. The condition called '*kifafa*' has only one interpretation here and it is 'epilepsy', caused either by tardiness in treatment of malaria or by heredity. Yet, most epilepsy patients in Muhimbili did not seek treatment for *kifafa* there, but were referred to Dr. Sayan Saleh and his colleagues by traumatologists and rheumatologists. According to Dr. Saleh, the treatment choices of the patients with *kifafa* are defined by their etiological beliefs and the availability of healthcare facilities.

Doctors want to bring *kifafa* under control and reduce uncertainty and fuzziness around it; *waganga* are interested in keeping the condition(s) ambiguous so that they can alleviate uncertainties for their clients. In the case of *kifafa* the healers benefit from the fuzziness and multiple interpretations of this misfortune; they render some certainty to their patients through divination in every individual case while the affliction itself remains obscure and fuzzy. Biomedicine attempts to organize and standardize the misfortune by turning it into a number of symptoms referred to as 'epilepsy'; contrary to *kifafa*, epilepsy is thought to be the same for every human body afflicted with it.

However, 'attempts to control, reduce or remove uncertainty may actually lead to the generation of further uncertainty or the accentuation of existing uncertainty' (Jenkins et al, 2005b: 17).

Just like in the case of *degedege*, those who have *kifafa* and their caregivers are driven by multiple reasons and considerations regarding treatment including efficacy, perceived etiology of this condition, financial concerns, the availability of the healthcare facility, advice from an authoritative family or community member, own experiences and even chance. For some *kifafa* is a condition that can be healed only by *waganga* due to its *uchawi* etiology (e.g. Mwarami Shiamte); some do explain their misfortunes as being caused by witchcraft, but follow a biomedical treatment pattern because it is perceived efficacious (Mohamed Salum); others prefer biomedicine and think it is efficacious (Nema Kalulu). Whatever the treatment choices might be, there is always some uncertainty and room for other possibilities; no treatment technique is ever *a priori*. People can be satisfied with the biomedical treatment but still allow for a chance of being bewitched (Mohamed Salum). The efficacy of biomedicine doesn't mean that there is no witchcraft:

We went to many *waganga*, but nobody could help my son. We don't believe those healers anymore. They are liars. But both *uganga* and *uchawi* do exist, and there are true healers who indeed have powers. There are conditions that can't be cured by doctors (From the interview with Suna Salum on June 26, 2012).

Thus, everything is possible and nothing is clearly defined and exclusive. Whatever reasons influence treatment decision-making, they are very flexible; this very flexibility makes the medical habitus of Kigamboni work and reproduce itself.

Chapter 5. *Kifafa*-related stigma?

In the previous chapters of the present thesis I analyzed the perceived etiology and treatment choices related to *kifafa*. Chapter 5 will be devoted to the way this condition is positioned in the social sphere and the status of those who have it. The first thing that comes in mind in relation to the social status of *kifafa* is the question of stigma, which has been raised in the literature on epilepsy in general and in Tanzania in particular (Jilek-Aall, 2010; Winkler et al, 2012, 2010 (a), 2010 (b), 2009; Rwiza et al, 1993 (a), 1993 (b); Mushi, 2011; Moshi et al, 2005; Matuja et al, 2001). I have already discussed these papers and the concept of stigma in the **Theoretical Framework** of this thesis. Yet, I will allow myself to stress once again that here I will use the following definition of stigma: stigma is a 'mark' (attribute, label) that links a person to undesirable characteristics (stereotypes), which involves separation, status loss, and discrimination in a power situation that allows the components of stigma to unfold. This is the definition used by Link & Phelan (2001).

Stigmatization of a person with a certain illness or condition (e.g. leprosy or HIV/AIDS) is a process largely induced by a quite natural fear, the fear of death. Besides the aspect of fear, stigma relates to the domains of life associated with morality. If a particular health-related misfortune is attributed to a morally deviant behavior, through which the otherwise hidden and intimate spheres of life are being disclosed, it can lead to the stigmatization of this affliction (Alonzo & Reynolds, 1995: 305; Campbell et al, 2007: 406; Deacon, 2006: 421; Holzemer et al, 2007: 548). For example, HIV/AIDS is often associated with sexual promiscuity due to the way it is transmitted (Deacon, 2006: 421); Roura et al, who did their research in rural Tanzania, call HIV/AIDS 'moral disease' (Roura et al, 2009). Labeling, separation and subsequently discrimination are not imposed out of hatred towards the 'mark' itself or towards the person with the stigmatized attribute; rather they are used as a self-protection mechanism against the illness. In this respect, stigma is something very different than discrimination. For example, racism is a form of discrimination, yet it is not stigma because it doesn't have the connotation of fear about it; neither is the belonging to 'the wrong' race labeled as immoral.

In order to better understand stigma it is useful to look at the literature devoted to HIV/AIDS. In most academic papers we see that stigma often comes out in the association with 'several disadvantages', as Amuri et al (2011: 378) call poverty, low education, rural surroundings and vulnerability. Moreover, stigma is seen as 'a major challenge for HIV prevention' both by the academia and the Tanzanian government (Ibid.). Fighting HIV/AIDS stigma is now a strategic priority as it is believed that stigma contributes to the spread of the pandemic while curbing prevention and care (Campbell

et al, 2007; Deacon, 2006; Holzemer et al, 2007; Odimegwu et al, 2013). Thus, in the literature devoted to HIV/AIDS-related stigma we find that stigma is included in the 'problem package' with poverty, bad education and vulnerable agency. As we established in the Theoretical Framework, vulnerability is not always negative and can be used as a means of negotiating better conditions (cf. Deacon, 2006: 422; Berbrier, 2002). Thus, stigma is not always bad; it must be approached in a very balanced way.

The article by Niehaus (2007) is very useful in terms of understanding the difference between stigma and discrimination. By analyzing the HIV/AIDS-related stigma in South Africa and showing how it manifests itself in practice, the author comes to a conclusion that 'the association of AIDS with death [...] is the main source of its stigma' (Niehaus, 2007: 848). As one of the author's informants put it, he could 'tolerate a corpse, but not a person who is dying' (Ibid.: 856). This omnipresence of death and fear are the main characteristics of stigmatization. The practice of excluding and even ostracizing people 'infected with death' falls in line with the whole idea of stigma and serves its purpose, which is protection from death. Niehaus also stresses the influence of the pro-biomedical institutions on the process of stigmatization:

[...] stigma is as much a product of public health campaigns that construct AIDS as a terminal illness, and of biomedical interventions that emphasise prevention rather than treatment, as it is of local concepts of death. In this respect, there is great need for critical reflexivity and introspection within biomedicine (Niehaus, 2007: 859).

With the issue of fear related to stigma comes the aspect of contagiousness (see the Theoretical Framework section), as the fear is usually stirred by the risk of getting a deadly (or rather perceived as deadly) disease or condition, which in turn mobilizes the defense reaction that may include stigmatization. Reflecting upon the reasons behind stigmatizing certain health-related conditions and not stigmatizing others, I concluded that the driving aspects of stigmatization are the local healing epistemologies and the two fears: the fear of death and the fear of contagiousness. The more a certain condition is feared, the more likely it will be stigmatized. At the same time, moral views and the medical habitus play a crucial part in determining which conditions are stigmatized and which are not. Various institutions (education, biomedicine, traditional medicine, academia, governments, NGOs, international organizations, religion, etc.) influence the habitus too.

In this chapter I will use the data from the semi-structured survey¹⁶, where I asked the participants who were not directly affected by *kifafa* to say whether this condition was contagious. Understanding that just answers to the survey questions are not sufficient for grasping such an

¹⁶ See the 12th question in the Appendix. The survey population comprised 105 people, who were not directly affected by *kifafa*.

intricate concept as stigma, I will also draw on my observations, open and semi-structured interviews and the opinions of those who have *kifafa* themselves about stigma and its components in relation to this particular condition. As always, I will start with the survey participants and their opinions and continue with the experiences of those who have *kifafa*.

Semi-structured survey participants

The participants of the semi-structured survey were asked to answer the question about the contagiousness of *kifafa*. Most respondents who thought that it was contagious said that *kifafa* was transmitted through *upepo* (the inhaling of digestive gases). Those who didn't think that this condition was contagious usually supported their opinion saying that the parents and caregivers of people with *kifafa* didn't get it, though they were in constant contact with those they took care of. It must be stressed that thinking that *kifafa* is contagious doesn't necessarily mean that it entails stigmatization or even discrimination.

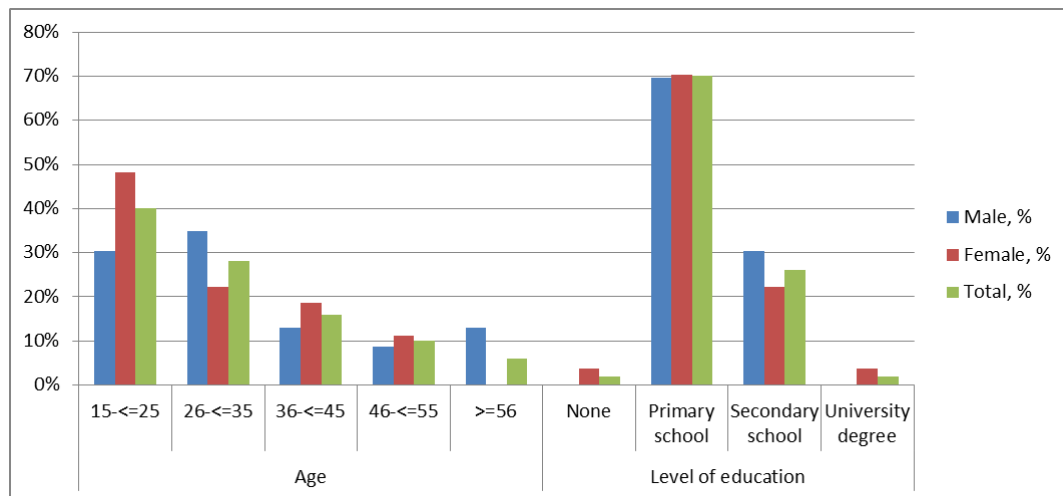
All of the respondents would still help a person with *kifafa* during a seizure if the convulsions happened in an unsafe place (e.g. next to the fire, in the water, etc.) despite the fear of contamination. Not helping a person (be it with *kifafa* or not) in need or in danger was considered shameful and unacceptable. Even if my respondents said that this condition was contagious through *upepo*, they all were in no doubt about what to do if they found themselves in a situation when they were running the risk of being infected with *kifafa* but still helping a person during a seizure or leaving this person in danger but being safe themselves. Everyone was very emotional supporting the former behavioral model.

In this section I will analyze the informants who supported the idea of the contagiousness of *kifafa* and those who didn't along the gender, education and age lines.

Contagious

Almost half of all the survey participants (48%) said that they thought *kifafa* was contagious, which accounts for 36% of all men and 66% of all women. Women are thus more inclined to think that *kifafa* is contagious through *upepo* than men. On Graph 15 we see how these 48% of the respondents are distributed by age, gender and education level. As we see, this opinion is more popular with the youngest women, with the popularity decreasing as the age grows; no females from the fifth age group said that *kifafa* was contagious. As for men, most of those who thought that this condition was contagious are found in the second age group, which is not surprising as the majority of male survey participants belongs to this group. Both for women and men, this interpretation is more popular with the youngest generation. Very few males and females with a university degree

would opt for this opinion; the same applies to people with secondary education. Most women and most men, who said they thought *kifafa* was contagious, have primary education.



Graph 15. Gender, age and education level of the survey participants, who said *kifafa* was contagious (%)

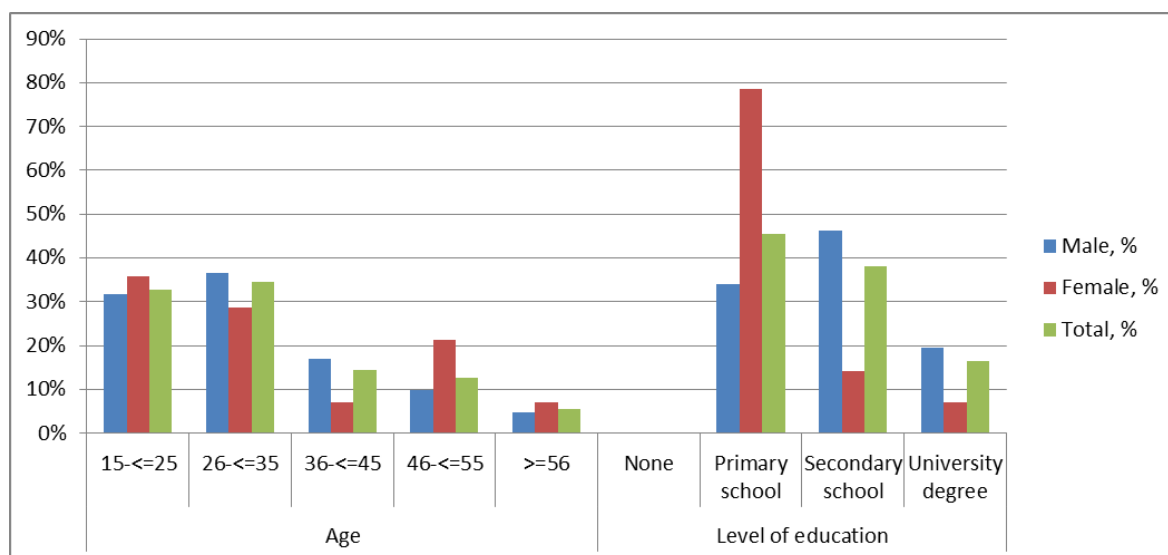
Uchawi was the most popular etiological explanation of *kifafa* (76% of the participants, who said they thought this condition was contagious) among the people who supported this interpretation. It was followed by *kuzaliwa nao* with 48%, *tumbo* with 32%, *kichwa* with 24% and *degedege* with 20% of the respondents. This popularity gradation is exactly the same for the people who said they would prefer traditional medicine as their first treatment choice (see Chapter 4). Thus, the beliefs about contagiousness are very closely intertwined with the treatment choices, preference towards traditional medicine and the etiology of *kifafa*. As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine and those who think that this condition is contagious prefer supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*). It should also be mentioned that all the traditional healers I interviewed said that *kifafa* could be transmitted through *upepo*; thus, the opinions of *waganga* are very influential in terms of defining whether this condition is contagious and subsequently forming its social image.

Not contagious

More than a half (52%) of the survey participants said they didn't think that *kifafa* was contagious. Contrary to the respondents of the previous section, this interpretation was more popular with men (64% of all males) than with women (34% of all females). Graph 16 shows how the participants of the survey who supported the opinion that *kifafa* is not contagious (*kifafa hakiambukizi*) are distributed by gender, age and education level. As we see, this opinion is more popular with the younger people, with the popularity decreasing as the age grows; most females from the fourth age group said that

kifafa was not contagious. As for men, most of those who thought that this condition was not contagious are found in the second age group once again as the majority of male survey participants belongs to this group. All of the males and half of the females with a university degree would opt for this opinion; most men with secondary education support this interpretation too. Most women who thought *kifafa* was contagious had primary education.

Most of the survey participants (53%) who said they didn't think that *kifafa* was contagious, supported the *ubongo* etiology of this condition. *Kuzaliwa nao* (inborn condition) was a bit less popular with 49% of the informants, followed by *uchawi* with 45%, *kurithi* (hereditary condition) with 38% and *kichwa* (head) with 36% of the respondents. The most popular interpretation was related to bodily cause (*ubongo*), which is not surprising given that biomedicine provides the same opinion about the contagiousness of *kifafa*. Yet, witchcraft and *kuzaliwa nao* are not dismissed as possible explanations even if biomedical interpretation is preferred. It again proves the plurality of ideas around *kifafa*.



Graph 16. Gender, age and education level of the survey participants, who said *kifafa* was not contagious (%)

People with *kifafa* and their social experiences

This section will be devoted to the experiences of those who have *kifafa* and of their caregivers concerning the social image of this condition. I will represent three case studies of three people with *kifafa* and try to understand how this condition is perceived by them and if it is related to any fear, shame, secrecy, discrimination or stigma.

Case 1. Saidi Juma Udagila

When I accidentally ran into Shabani, whom I had met during my first trip to Tanzania in 2009, and asked him if he knew anyone with *kifafa*, he said that his friend Saidi had it and offered to show me where he lived. I gratefully accepted the offer and on our way to Saidi's house we decided that Shabani would become my research assistant. It turned out that Johnny's friend lived with Shabani's younger sister Amina, who took care of him, cooked his food and did his laundry. I was quite surprised at such an arrangement and asked Shabani how Saidi ended up with Johnny's sister.

Shabani explained that Saidi's family and his used to be neighbors and the boys were very close friends. Later on, Saidi's parents divorced and his mother had to work hard to support herself and her son, who by that time already had *kifafa* and couldn't find a job. She had to move to Dar es Salaam and asked Shabani's sister to give Saidi shelter till she was well-established in the city; she also promised to visit and send money. Years passed by but Saidi remained with Amina; his mother only visited him rarely and almost stopped sending money. When I asked Shabani's sister why she agreed for Saidi to stay with her, she said that Saidi was a good friend of the family and he needed help so she couldn't refuse. She added that he wasn't a burden because he worked little jobs (*kazi ndogo*) and gave Amina the earned money so she could buy food and cook for him.



Saidi Juma Udagila

Those little jobs kept Saidi busy almost every morning; Shabani and I would come to talk to him but he would be out. Eventually on July 12 he was home and I had a chance to interview him. Saidi was forty-one and had his first seizure when he graduated from primary school. His mother then rushed him to a number of healers but they couldn't help. Later on Saidi was taken to a hospital, diagnosed

with epilepsy and prescribed Carbamazepine (an anticonvulsant). The pills helped and his seizures became less frequent. Saidi spent about 5000 Tsh (2.50€) per month on medication, which for him was a large sum of money. He said that sometimes his mother brought him the pills when she visited otherwise he managed to earn some money doing his *kazi ndogo*.

Saidi confessed that he wanted to build houses but was refused the job; he also never married. When I asked him why, he said that he had no education so he couldn't find a permanent job and no house to bring a wife to; that was why no woman would marry him. Overall, Saidi didn't feel like he was treated any differently than any other Kigamboni resident: he had friends, he didn't hide his condition and wasn't ashamed of it. When asked what other people thought about the contagiousness of *kifafa*, Saidi said that nobody he knew thought it was contagious. Though, Amina added that there were some people who thought that this condition was transmitted through *upepo* but they were few and didn't treat Saidi any differently. If Saidi had a seizure in the sun or somewhere far from the house, people would move him into the shade, wait till the convulsions stop and help him to get back home.

Case 2. Hamis Osman Hamis

We were referred to Hamis by an old lady who knew his grandmother; the grandmother herself was of the honorable age of seventy-five but insisted on showing us the way to her daughter's house despite her multiple health problems. As we followed the woman, she was telling us how old she was and how her feet and legs hurt and asking me if I knew any medicine that could cure them. We politely answered bibi Ghanima with '*Pole sana*' (Sw., 'So sorry for that') and waited when she stopped to show us her feet and legs that caused her so much trouble. I explained to her that I was not a doctor but just a researcher and said how sorry I was for not being able to help.

Finally, we reached our destination and got introduced to Hamis Osman's mother Fadhila. She said that Hamis was not home and was drinking beer with friends. She invited us in and told one of her younger children to go and fetch Hamis. In the meanwhile we exchanged polite greetings, which included asking about the state of health of the children. Unfortunately one of Fadhila's sons was having a stomachache and had to miss one day of work. Politeness demanded that we check on Rashidi and greet him, which we did. The young man was lying in bed in a T-shirt and underpants not at all bothered by our presence; he described what exactly troubled him in great detail and again we expressed our sympathy. Shabani also advised Rashidi to go to the local dispensary and get tested.

I'm telling this story because in my opinion it proves how much affliction is tolerated and seen as something natural and nothing shameful, how much it manifests itself as a social event or, in this

case, a topic for conversation. People are very eager to talk about health, demonstrate their wounds and the body parts that give them pain (to a certain limit, of course), discuss the treatment patterns, medicines, efficacy and their health-related experiences. I was the person many residents of Kigamboni saw for the first time in their lives when I interviewed them, yet they shared their private matters with me as if we had been friends for years. Self-excluding from a sick person or showing any discomfort induced by his/her presence was considered extremely impolite and even despicable. Showing compassion, sympathizing, giving advice, examining and even touching was on the contrary a sign of good will and good personality.



Hamis Osman Hamis

Soon, Hamis entered the room where we were talking with Rashidi and we followed him outside for the interview. Fadhila had already brought us chairs and was sitting in the shade when we got out of the house. It turned out that Hamis was twenty-seven and had his first seizure when he was about twenty years old. Fadhila then took him to an herbalist, who asked 10 000 Tsh (about 5€) for his services. Hamis got better (*alipata nafuu*) and didn't have seizures for three months; yet, *kifafa* returned afterwards. Fadhila said that if they had more money, they would go to a doctor but those demanded a lot (*mapesa mengi kwa madaktari*). The etiology of *kifafa* was obscure for both the mother and the son, yet they didn't think it was *uchawi*.

Hamis completed his primary school education and studied in the secondary school for three years; he had to drop from school due to his condition. He worked as a loader of sand and lived with his parents; Hamis had no wife, yet he had many friends who knew about his condition and helped him during seizures. In fact, his co-workers, neighbors and acquaintances all knew that Hamis had *kifafa*, which he never tried to hide or was ashamed of. According to Fadhila, nobody thought that *kifafa* could be transmitted through *upepo*.

Case 3. Majuma Saidi

We had to take a long walk from Mjimwema where we interviewed some people and a young woman who had *kifafa* to get to Kibugumo. Shabani knew bibi Fupi from this village; he used to buy baskets from her, which he then sold to the tourists at the beach. We stopped by bibi Fupi's house and after a small chat asked her to refer us to someone who had *kifafa*. Bibi then showed us to Majuma's house. It was almost lunch time and a young woman in a kerchief was cooking something in a big pot. This was Majuma, who greeted us and agreed to be interviewed.

Majuma Saidi was twenty-three and had her first seizure at the age of seven. She herself firmly insisted that she had been bewitched. Once she was going back home from a shop and saw a very tall man who was sewing a shirt (*kanzu*). The man looked at her unkindly and by the time she got home she had had a fever. Since that time Majuma had been taken to at least ten *waganga* who were based in different parts of Tanzania, one was from Kilwa even (Kilwa is one of the coastal districts of Tanzania, it lies to the south from Dar es Salaam). When all the healers failed, Majuma switched to biomedicine, which couldn't cure her either, though she had been to a number of healthcare facilities in Dar es Salaam (Outpatient Clinic at Tegeta, Amana Hospital, Mlandizi and Mwendu Dispensaries).

The young woman said that they had spent so much money on trying to cure her *kifafa* that it would be enough to buy a new house; Majuma added that she had lost hope of recovery. She used to engage in small trade (*biashara ndogo*) to earn money, but she had to stop because of the seizures, which could be as frequent as seven times per day. When I first talked to Majuma she had just begun taking medicines she had bought from a healer. The medicines made the seizures less frequent: she could have up to two of them per day. Majuma said that if the medicines fail to cure her, she would go to another *mganga*.

As for social life, Majuma had many helping friends; the neighbors also knew about her *kifafa* and were willing to watch her while Majuma's mother was at work. Nobody was afraid of getting *kifafa* from her through *upepo* or any other way. Majuma didn't have a boyfriend though there were young

men interested in her; she said that she was afraid of getting pregnant and then having to raise the baby on her own. Her neighbor Asma dated a man, who refused to marry her and left her alone with a child, so Majuma was afraid of repeating her friend's fate.



Majuma Saidi

Majuma's mother didn't allow her to go anywhere alone as she was worried about her daughter. Nevertheless, Majuma confessed that she still could go rather far away from the house on her own, especially when her seizures became less frequent. As the oldest daughter, Majuma was responsible for cooking, cleaning, washing the dishes, doing laundry and all the housework. I noticed some burns on the young woman's arms, which she said she got when she had a seizure while cooking next to the fire.

During my second research span in the winter of 2013 I got to know Majuma, her family and friends better. I asked for permission to come and see the young woman every day and spend time with her, talk and help with the household duties (laundry, cooking, cleaning). Majuma's mother agreed to that and suggested that I should also teach her daughter how to read and write. Majuma was only able to study for seven months when she was a child; then she had to drop from primary school because of her *kifafa*. It turned out that Majuma was taking the pills prescribed by a doctor and the medicines given her by a healer simultaneously. Her seizures became less frequent and she was in much better mood than when I last saw her.

I was also introduced to Asma, Majuma's neighbor who had a toddler son and spent a lot of time with the young woman. We would often seat together on a *mkeka* in the shade of a high mango tree, talk, laugh and exchange our life experiences. Teaching Majuma was also part of our daily routine; we started with the alphabet and learning how to write the letters. She was a committed student but had very bad memory; she couldn't memorize more than four letters, though we would practice for many days.

Once I witnessed Majuma having a seizure; she knew it was coming because of the collywobbles, which were always signaling the start of it. Asma and I helped her to a *mkeka* inside the house; Asma said it was better to leave her there till the seizure stops. We moved to another room, from which we could still see Majuma convulsing. It all lasted for about fifteen minutes, then she came to her senses. She was her usual self and remembered that she had a seizure. Asma had witnessed many Majuma's seizures and behaved in her usual way: laughing and playing with her son Abduli.

Stigma?

When I came back to Kigamboni in January 2013 and started doing follow-up research, I accidentally ran into a young woman who had *kifafa*. Pili was on her way back home from the Kibada dispensary when she saw me walking to interview one of my informants who lived in the vicinity. Curious about the weird *mzungu* (European) who for some reason was walking instead of taking a car, she greeted me and asked what I was doing in Tanzania. I explained my research to her and it turned out that Pili had *kifafa*.

She told me that they had given her an id card (Sw., '*kitambulisho*') at the dispensary so that she could be helped in case of a seizure. In the id there were Pili's full name and her age, a picture of her, her home address and a cell phone number of her contact person. She explained that she often lost memory after a seizure and couldn't find her way back home. So the id was very helpful and served Pili well many times. People were always happy to help her and even took time to walk her home.

Having read quite some literature on epilepsy in Tanzania, I was expecting to find unhappy and suffering people with *kifafa*, discriminated against, shunned and stigmatized. I was looking for stigma and couldn't find it. At first I thought that I was doing something wrong or my research techniques were flawed. But little by little the smallest doubt I had about the existence of stigma around *kifafa* was destroyed; this condition was not discriminated against and certainly not stigmatized. From the open interviews I learned that it was not shameful to have *kifafa*, from the survey I found out that despite that there were many respondents thinking that this condition was transmitted through

upepo, they all would still help a person with *kifafa* if it was necessary. Thus, *kifafa* had no aspect of fear about it, which already put the existence of stigma out of the question.



Pili and her *kifafa* id card

Interviewing people with *kifafa* and their relatives I learned that they didn't feel discriminated against, were not ashamed of their condition and never had to conceal that they had it from anyone. They had friends and neighbors who were eager to help them, many of them had jobs (e.g. Mwarami and Hamis), though in Kigamboni finding a job was difficult even for totally healthy people. Whatever restrictions people with *kifafa* had were physical rather than social. There was no secrecy around *kifafa*, it was tolerated, accepted and considered a condition that could befall anyone. Not helping, failing to care, being rude to people with *kifafa* was considered inappropriate and condemned by the public opinion. The caregivers were ready to spend substantial sums of money on treating their children or relatives with *kifafa* even in most cases they couldn't really afford it. Even the fact that biomedical facilities gave their *kifafa* patients ids with personal information written on them and thus available to anyone, proves that this condition is not discriminated against left alone stigmatizing. Indeed, this id is a label, but it has no negative connotation because disclosing the identity of a person with *kifafa* is not dangerous for him/her as this affliction is not hidden. In other words, everybody knows anyway. It also must be stressed that labeling is only an aspect of stigma, which taken alone doesn't signal that a certain health-related misfortune is stigmatizing.

During my second research span I was unfortunate to catch some skin rash, which suspended my fieldwork for a while. When I felt better and returned to Kigamboni and told my research assistant

that it was better for him not to shake hands with me because I might be contagious, he shook hands with me nonetheless. He did that not to make me feel ashamed, excluded or uncomfortable in any way. Risking offending me even slightly was perceived as much worse than running the risk of getting ill. Thus, in Kigamboni *kifafa* is as accepted and tolerated as any other misfortune; this applies to the multiple etiological interpretations of this condition as well.

As we established in the previous chapters, *kifafa* is a fuzzy set for the residents of Kigamboni and is surrounded by uncertainty. In the present chapter I argue that there is no *kifafa*-related stigma in Kigamboni. Indeed, it is very hard for a fuzzy condition to be stigmatizing, as the concept of stigma presupposes certainty (a clear set of beliefs, morals, the idea of the 'norm', etc.). HIV/AIDS with its institutionally constructed image (cf. Niehaus, 2007: 859) is stigmatizing also due to the crispness of the cognitive categories related to it. Thus, I hypothesize that *kifafa* is not stigmatizing partly due to the ambiguities surrounding it. The fuzziness derives from the experience-oriented healing epistemology of Kigamboni, which falls in line with Stroeken's (2012) argument about radical empiricism and Laughlin's (1993: 23) theory of the experiential proximity.

Conclusion

From the literature on epilepsy in Tanzania we learn that this illness is a source of stigma. We have established that we can only talk about stigma when the stigmatized condition is feared by those who stigmatize. The fear of death as an aspect of stigma makes it very different from discrimination, which includes labeling and separation but has nothing to do with the fear. With the issue of fear related to stigma comes the aspect of contagiousness, as the fear is usually stirred by the risk of getting a deadly (or rather perceived as deadly) disease or condition, which in turn mobilizes the defense reaction that may include stigmatization. Various institutions (mostly pro-biomedical) are also responsible for promoting the idea of *kifafa*-related stigma; by fighting it they contribute to it.

In this chapter I have analyzed the answers of the survey participants related to the contagiousness of *kifafa*. Most of the informants (52%) said they didn't think that *kifafa* was contagious; 48% of the respondents thought that this condition was transmitted through *upepo*. Women were more inclined to think that *kifafa* was contagious than men: only 36% of all men and 66% of all women supported the *upepo* interpretation. Contrary to that, the interpretation of *kifafa* not being contagious was more popular with men (64% of all males) than with women (34% of all females).

The opinion that *kifafa* is contagious was supported mostly by people with primary education, the youth and the elderly, and the women. The opposite opinion was widespread among people with

secondary and higher education (also females who finished primary schools), men in general and the people from the second age group; the elderly also supported this opinion. All of the respondents would still help a person with *kifafa* during a seizure if the convulsions happened in an unsafe place (e.g. next to the fire, in the water, etc.) despite the fear of contamination.

Most of the survey participants (53%) who said they didn't think that *kifafa* was contagious, supported the *ubongo* etiology of this condition. Thus, the most popular interpretation was related to bodily cause (brain), which is not surprising given that biomedicine provides the same opinion about the contagiousness of *kifafa*. Yet, witchcraft and *kuzaliwa nao* are not dismissed as possible explanations even if biomedical interpretation is preferred. It again proves the plurality of ideas around *kifafa*.

Uchawi was the most popular etiological explanation of *kifafa* (76% of the participants) with those who said they thought this condition was contagious. The popularity gradation for this contagiousness opinion was exactly the same for the people who said they would prefer traditional medicine as their first treatment choice (see Chapter 4). Thus, the beliefs about contagiousness are very closely intertwined with the treatment choices, preference towards traditional medicine and the etiology of *kifafa*. As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine and those who think that this condition is contagious prefer supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*). The opinions of *waganga* are also very influential in terms of defining whether this condition is contagious and subsequently forming its social image. Most healers label *kifafa* as contagious, contributing to the biomedical discourse on stigma. Nevertheless, I found no evidence of discrimination or stigmatization related to this condition in Kigamboni.

From the represented case studies we see how much misfortune is tolerated and treated as something natural and nothing shameful, how much it manifests itself as a social event. People are very eager to talk about health, demonstrate their wounds and the body parts that give them pain (to a certain limit, of course), discuss the treatment patterns, medicines, efficacy and their health-related experiences. Self-excluding from a sick person or showing any discomfort induced by his/her presence is considered extremely impolite and even despicable. Showing compassion, sympathizing, giving advice, examining and even touching are on the contrary the signs of good will and good personality.

People with *kifafa* and their relatives don't feel discriminated against, they are not ashamed of their condition and never had to conceal that they had it from anyone. They have friends and neighbors who are eager to help them, many of them have jobs (e.g. Mwarami and Hamis), though in

Kigamboni finding a job is difficult even for completely healthy people. Whatever restrictions people with *kifafa* have are physical rather than social. There is no secrecy around *kifafa*, it is tolerated, accepted and considered a condition that can befall anyone. Not helping, failing to care, being rude to people with *kifafa* is considered inappropriate and condemned by the public opinion. The caregivers are ready to spend substantial sums of money on treating their children or relatives with *kifafa* even in most cases they can't really afford it. Even the fact that biomedical facilities give their *kifafa* patients IDs with personal information written on them and thus available to anyone, proves that this condition is not discriminated against left alone stigmatizing.

The absence of stigma around *kifafa* falls in line with the general tolerance and acceptance towards afflictions and misfortunes in Kigamboni. As much as the epistemology allows for multiple etiological interpretations of this condition, it leaves room for the bodies afflicted with it. The bodies are not identified with *kifafa*; rather they are seen as unfortunate ones who can't help having this condition. Thus, people with *kifafa* are seen as having no agency vis-à-vis this misfortune and are treated exactly the same as other residents of Kigamboni. In the social domain the *kifafa* of a person and the person himself are seen and treated separately; *kifafa* is feared, but the person having it is not. Moreover, the well-being of that person overweighs the fear of *kifafa*, which is proved by the eagerness of my informants to help people during seizures despite thinking they could get *kifafa* in the process. *Kifafa* is not a moralized misfortune in the sense that it doesn't relate to sexuality or any other sphere of life that normally remains hidden. The ambiguous nature of *kifafa* might to a certain extent contribute to the non-production of stigma related to this affliction.

Conclusion

Now that all the five chapters are written and the research questions are addressed, it is time to draw conclusions. I have given a brief summary of how *uganga* has been evolving over the years and how its ambiguity has been making it work in the first chapter; I also demonstrated that various institutions have been affecting the healing in Tanzania. In the following chapter I represented the multiple causes of *kifafa*, argued that it was a fuzzy set for the residents of Kigamboni, and analyzed the research population along the gender, age and education lines. The third chapter was devoted to the condition of *degedege*, which was perceived as one of the etiological explanations of *kifafa* and was often identified with it. The treatment choices of the people who have *kifafa* and the healing techniques of *waganga* used to treat this condition are addressed in the fourth chapter. In the fifth chapter I argued that there was no stigma around *kifafa* and that it was perceived as any other misfortune by the residents of Kigamboni. So, what have we learned?

From the first chapter we conclude that the plurality of explanations around *kifafa* stems from the pluralism of *uganga* itself, which colonial authorities were so much struggling with. The Tanzanian Government too is trying to structurize the healing domain and to promote specific treatment types along with popularizing its own healing epistemology. The pro-biomedical discourse on health-related conditions like *kifafa* is supported by the officials of Tanzania; it does its job of introducing the idea of epilepsy-related stigma.

The role and status of *uganga* have been changing over the centuries. In pre-colonial times *uganga* and *uchawi* were not institutionally and epistemologically separated. Rather, they were perceived as a unified flexible bulk of inter-dependent practices. The healers were very much respected within the community; the chiefs often consulted the diviners and asked for their advice on some important decisions. *Waganga* were not only healing individuals, but also performed socially important rituals like rainmaking and fighting witches.

The position of *uganga* was strengthened by the Ngoni migrations, as there was high demand for protective charms and war concoctions. In the 19th century *waganga* were travelling with large caravans protecting both the caravan people and their loads. Geographical borders were crossed, opening the gates to the therapeutic knowledge of different ethnic groups inhabiting East Africa. The healers exchanged knowledge and established connections by crossing borders; the porters came back home with money received for their work. It all brought the commodification of *uganga* along; the roots of the healing 'individualization' are also to be found in the pre-colonial period: travelling

waganga could no longer 'fix' communities and fully engage in the social lives of their patients, so they just treated individual clients.

The first European travelers who came to East Africa were baffled with traditional healing systems and defined them as backward compared to their own. They could tolerate herbalism because it worked on the physical level, but psychological and communal healing practices of *uganga* were incomprehensible. The Maji Maji rebellion fully demonstrated the political importance of *waganga*; the lessons of the riot were learned by the Germans and the British who took over the power in Tanganyika. The new colonial administration decided to have *waganga* under complete control. First of all, the British legislation legally separated *uchawi* from *uganga* and thus deprived traditional medicine of its social functions; the healing was taken out of the public domain and moved into private one. Herbalism as a sort of 'pre-science' was acknowledged as useful for the development of healthcare.

Tanzania still uses the witchcraft ordinance from the colonial times. The structural adjustment reforms and the liberalization of the market have speeded up the ongoing processes of commodification, institutionalization and individualization of *uganga*. The social status of traditional healers is now much lower than it used to be in pre-colonial times. Modernity wants the knowledge of the herbalists to be transferred into pills as much as it needs to control *uganga*.

In Kigamboni people have access to both biomedical and traditional healthcare facilities. The healing epistemology and the medical practices of the residents are very open and usually driven by experience. Such a healing cosmology is radically empirical due to its acceptance of different medical practices and empirical nature. According to Laughlin (1993: 23), the consciousness being oriented on direct experience results in the fuzziness of particular cognitive categories (in this case, those related to *uganga*).

The perceptions of *uganga* have been changing over the years but most of them have their roots in pre-colonial times. These perceptions still shape the policies of NGOs and governments in relation to healing as well as they influence the local etiology of afflictions, the treatment choices and medical epistemologies in general. Certain conditions are being constructed as stigmatizing in the course of (and even as a means of) fighting them. In the literature *kifafa* is now identified with the biomedical epilepsy and labeled as stigma-related.

From the second chapter we learn that the symptoms of *kifafa* are well-known to most residents of Kigamboni but the etiology of this condition is rather vague and obscure. I came across fourteen different explanations of *kifafa*'s etiology. Despite somewhat controversial and sometimes mutually

excluding (it may seem) nature of the interpretations, people almost always suggest them together. It is due to the individualistic approach to *kifafa*, the etiology of which changes in every particular case. The word '*kifafa*' thus relates to certain symptoms, which are more or less the same for everyone with this condition, but not to the same etiology. Every case of *kifafa* is considered to have different (and sometimes multiple) causes, which allows for the etiological plurality in Kigamboni.

Those who are not directly affected by *kifafa* have the most pluralistic etiology of this condition. The most popular explanations among them are *uchawi*, *kuzaliwa nao*, and *ubongo*. The *uchawi* explanation is predominant in all the three population groups (those who are not directly affected by *kifafa*; those who have it; traditional healers); the *degedege* and *ubongo* causes are popular with people who have *kifafa* and their caregivers, while *uchawi*, *tumbo* and *degedege* are equally predominant among traditional healers.

The etiological field of explanations around *kifafa* is very vast and even confusing but not surprising given the very nature of *uganga* and the healing epistemology of Kigamboni. The ambiguities and the multiplicity of interpretations, which the local medical habitus allows for, are integral for the healing cosmology itself and for its reproduction. The healers are comfortable with the fuzziness and multiple interpretations of *kifafa*; they render some certainty to their clients through divination in every particular case while the affliction itself remains obscure and ambiguous. Biomedicine, on the contrary, tries to clarify the misfortune and turn it into comprehensible and manageable 'epilepsy'.

The third chapter was devoted to *degedege*, the only etiological explanation of *kifafa* covered by literature. The popularity of *degedege* among scholars is very much defined by the identification of this condition with malaria. If *degedege* wasn't associated with biomedical malaria, we probably wouldn't have literature on this condition at our disposal. This makes the coverage of *degedege* in literature very accidental: the other multiple causes of *kifafa* are neglected by the academia mostly because they do not add to the biomedically triggered malaria debate. *Kifafa* is identified with epilepsy, which is described as stigmatizing in the literature. At the same time the symptomatically similar *degedege* is not represented as stigma-related due to being associated with non-stigmatizing malaria. Thus, *kifafa*-related stigma is to a large extent a construct of the pro-biomedical institutions. Once again we see multiplicity denied by the biomedical discourse and while it is this very plurality that makes the healing epistemology of Kigamboni work.

I made an attempt at providing a better understanding of the relationship between *kifafa* and *degedege*. Most my informants, including traditional healers, called *degedege* '*kifafa cha utoto*' (Sw., 'childhood epilepsy') and said that symptomatically the two conditions were very similar except for *kifafa* being non-febrile. The treatment used for *kifafa* and *degedege* by *waganga* was reported to

be the same or very similar by my informants. The age range of *degedege* was something all the interviewees agreed on: up to 4-5 years of age. Having *degedege* as an adult was a sign of being bewitched, according to one of my informants. Otherwise, *degedege* was seen as childhood condition only. The literature, though, suggests that *degedege* may befall anyone, be it a child or a grown-up. In Kigamboni I met nobody who supported this claim.

Kifafa manifests itself with the symptoms similar to *degedege* but is usually described as a non-febrile condition. Thus, the two conditions can be easily confused with one another by non-professionals. As for etiology, *degedege* is attributed to the spirit bird (or *shetani*), *uchawi*, malaria, *kuvunja mwiko* (in this case failure to abstain from sex), and *mazingira* (here mostly related to the places where mosquitoes breed) in the literature. During my research I came across only three interpretations of the causes of this condition: malaria, which correlates with the biomedical paradigm, *mashetani* and *uchawi*. *Kifafa* is related to *degedege* etiologically; first of all, the latter is perceived as one of the causes of the former; secondly, *degedege* is explained through *kifafa*: this condition is referred to as '*kifafa cha utoto*'.

The literature doesn't focus on this etiological relationship between the two conditions; epilepsy is only mentioned a couple of times as having similar symptoms. Malaria is on the contrary always present in the literature on *degedege*, sometimes seen as the cause of this condition, sometimes referred to as its biomedical twin, but always paired with it and even identified through it. Most scholars tend to take this complex relationship between the two conditions for granted and call *degedege* 'severe/cerebral malaria' or 'malaria-induced febrile convulsions'. In Kigamboni those who think that *degedege* is caused by malaria are not always eager to treat this condition at the hospital, while they are fine with treating malaria there.

Kifafa is often characterized as incurable, while *degedege* can be successfully cured by *waganga*. According to the literature, most caregivers use traditional and biomedical methods simultaneously to treat *degedege*. The reasons behind this treatment behavior are not only etiological; they are related to various factors like financial issues, proximity of the healthcare point, convenience, efficacy of the provided treatment, pressure from the influential community members, and even random chance.

Many parents are reluctant to take their children to hospitals in case of *degedege* because of the fear of injections. This idea is widespread in the literature and is also confirmed by my informants. It is thought that puncturing the skin with a needle can be fatal for the child with *degedege*, as the malevolent spirit penetrates the body through the punctured skin. Due to this fear many parents

prefer traditional treatment with medicinal baths, amulets, fuming with elephant dung, and drinking herbal concoctions.

The matter of efficacy is a very important factor in treatment decision-making. Many caregivers are dissatisfied with the services of the biomedical practitioners and address traditional healers. The efficacy of traditional treatment is acknowledged in the literature but downplayed and explained by 'nosological fusion' between severe malaria and febrile convulsions. Some scholars argue that the latter is not fatal and easily cured by lowering the body temperature. Thus, according to these authors, healers intervene and take credit for cases that would have resolved spontaneously. Low success rate of the hospitals in treating *degedege* is explained by significant delay on the part of the parents due to transportation difficulties and financial hardship.

I represented three cases of *degedege* in order to show how caregivers make their treatment decisions and what kind of reasoning is behind them. Kishtobe was driven by the perceived etiology of Ali's condition rather than the treatment efficacy. Financial issues were in play as well, but they were less important than etiological concerns. Johari Hatib was in the middle of the income hierarchy of the three cases. Her treatment decision-making was shaped by her belief in biomedicine: she persistently took her sons to the hospitals in spite of being dissatisfied with the diagnoses and treatment outcomes. Johari said she would consider addressing a healer only after exhausting all biomedical treatment opportunities. Thus, Kishtobe was inclined to choose traditional medicine no matter what, Johari – biomedicine, and Hadija – efficacy. Of course, it is not to say that if the circumstances were to change these three mothers would still follow the same pattern (cf. Kamat, 2008a: 68).

The fourth chapter proved that the treatment choices of the residents of Kigamboni depended to a large extent on their etiological interpretations of *kifafa*. Most people who were not directly affected by *kifafa* said they would prefer to address a healer as their first choice in case they or their relatives had this condition. Yet, 48% of the respondents would consider biomedicine as a more desirable option. Women were more positive about traditional medicine than men, as were people of older age and those with low education level. Biomedicine, on the contrary, was supported by every survey participant with a university degree, most men and most informants with secondary education.

Among those who preferred biomedicine as their first treatment resort, most respondents supported the biomedical etiology of *kifafa* and attributed this condition to bodily causes (*kichwa*, *ubongo*, *kurithi*). Yet, witchcraft was not dismissed as a possible explanation even if biomedical treatment was preferred. It again proves the plurality of ideas around *kifafa*, which allows for both biomedical rationality and firm belief in supernatural powers. The biomedical etiology doesn't necessarily mean

that there is no room for doubt and uncertainty in the form of other explanations (e.g. witchcraft and *majini*).

As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine preferred supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*). At the same time, biomedical ideas about the etiology of *kifafa* were not dismissed, they were too considered valid and possible. The inherently biomedical explanation *kichwa* was incorporated into the traditional etiology of *kifafa*, largely promoted by *waganga*. Once again we see ideas travelling from one medical domain to another; nothing is clearly defined, all the interpretations are intertwined and accepted. The two medical domains are not antagonized, rather they are perceived as treatment options that could be used regardless of the etiological beliefs. The epistemology of healing in Kigamboni allows for every explanation, while the Western one does its work through excluding particular interpretations in search of a clear-cut solution.

I represented four case studies of the treatment techniques applied by the local traditional healers in Kigamboni. All of them used medicinal herbs to treat *kifafa*, though only one *mganga* (Mariam Kondo) was explicitly an herbalist. The others were using multiple healing methods including divination with Quran and genies; to prove their therapeutic abilities most healers attributed their knowledge to their ancestors, who had taught them how to treat people. Most *waganga* were 'wounded healers', which means that they got their gift through recovering from a deadly condition. Having recovered, they obtained the power to heal other people; usually *majini* or other supernatural patrons spoke to them and told them how to treat the patients.

Getting a biomedical treatment for *kifafa* is a completely different experience than addressing a healer. Muhimbili National Hospital as an institution and as a building represents a border between discourses, which is nevertheless frequently crossed. The very whiteness, cleanness, decoration minimalism and hurriedness of the employees demonstrate the difference in the approaches towards treatment in biomedicine and traditional medicine. Even the language used is not the one spoken outside the hospital doors: here English is preferred to Swahili. The condition called '*kifafa*' has only one interpretation here and it is 'epilepsy', caused either by tardiness in treatment of malaria or by heredity. Yet, most epilepsy patients in Muhimbili did not seek treatment for *kifafa* there, but were referred to Dr. Sayan Saleh and his colleagues by traumatologists and rheumatologists. According to Dr. Saleh, the treatment choices of the patients with *kifafa* are defined by their etiological beliefs and the availability of healthcare facilities.

Those who have *kifafa* and their caregivers are driven by multiple reasons and considerations regarding treatment including efficacy, perceived etiology of this condition, financial concerns, the availability of the healthcare facility, advice from an authoritative family or community member, own experiences and even chance. For some *kifafa* is a condition that can be healed only by *waganga* due to its *uchawi* etiology (e.g. Mwarami Shiamte); some think they could have been bewitched, but follow a biomedical treatment pattern because it is perceived efficacious (Mohamed Salum); others trust biomedicine and its efficacy (Nema Kalulu). Whatever the treatment choices might be, there is always some uncertainty and room for other possibilities; no treatment technique is ever *a priori*. People can be satisfied with the biomedical treatment but still allow for a chance of being bewitched (Mohamed Salum). The efficacy of biomedicine doesn't mean that there is no witchcraft. Thus, everything is possible and nothing is clearly defined and exclusive. Whatever reasons influence treatment decision-making, they are very flexible; this very flexibility makes the medical habitus of Kigamboni work and reproduce itself.

The last chapter is devoted to the relationship between *kifafa* and stigma. In the literature on epilepsy in Tanzania we read that this illness is a source of stigma. Yet, we can only talk about stigma when the stigmatized condition is feared or morally defied by those who stigmatize. The fear of death and the moral aspect of stigma make it different from discrimination, which includes labeling and separation but has nothing to do with the fear and morality. With the issue of fear related to stigma comes the aspect of contagiousness, as the fear is usually stirred by the risk of getting a deadly (or rather perceived as deadly) disease or condition, which in turn mobilizes the defense reaction that may include stigmatization.

I analyzed the answers of the survey participants related to the contagiousness of *kifafa*. Most of the informants (52%) said they didn't think that *kifafa* was contagious; 48% of the respondents thought that this condition was transmitted through *upepo*. Women were more inclined to think that *kifafa* was contagious than men: only 36% of all men and 66% of all women supported the *upepo* interpretation. Contrary to that, the interpretation of *kifafa* not being contagious was more popular with men (64% of all males) than with women (34% of all females).

The opinion that *kifafa* is contagious was supported mostly by people with primary education, the youth and the elderly, and the women. The opposite opinion was widespread among people with secondary and higher education (also females who finished primary schools), men in general and the people from the second age group; the elderly also supported this opinion. All of the respondents would still help a person with *kifafa* during a seizure if the convulsions happened in an unsafe place (e.g. next to the fire, in the water, etc.) despite the fear of contamination.

Most of the survey participants (53%) who said they didn't think that *kifafa* was contagious, supported the *ubongo* etiology of this condition. Thus, the most popular interpretation was related to bodily cause (brain), which is not surprising given that biomedicine provides the same opinion about the contagiousness of *kifafa*. Yet, witchcraft and *kuzaliwa nao* are not dismissed as possible explanations even if biomedical interpretation is preferred. It again proves the plurality of ideas around *kifafa*.

Uchawi was the most popular etiological explanation of *kifafa* (76% of the participants) with those who said they thought this condition was contagious. The popularity gradation for this contagiousness opinion was exactly the same for the people who said they would prefer traditional medicine as their first treatment choice. Thus, the beliefs about contagiousness are very closely intertwined with the treatment choices, preference towards traditional medicine and the etiology of *kifafa*. As opposed to those who would choose biomedicine as their first resort, the participants in favor of traditional medicine and those who think that this condition is contagious prefer supernatural interpretations of *kifafa* rather than physical and body-related (e.g. *uchawi*, *kuzaliwa nao*). The opinions of *waganga* are also very influential in terms of defining whether this condition is contagious and subsequently forming its social image.

People with *kifafa* and their relatives don't feel discriminated against, they are not ashamed of their condition(s) and never had to conceal that they had *kifafa* from anyone. They have friends and live their social lives the way their healthy peers do. Whatever restrictions people with *kifafa* have are physical rather than social. Failing to care about people with *kifafa* is disapproved by the local etiquette and morals. The caregivers spend substantial sums of money on treating their children or family members with *kifafa* even in most cases they can't really afford it.

The absence of stigma around *kifafa* is due to the general tolerance and acceptance towards affliction in Kigamboni. The body suffering from *kifafa* is not perceived as related to the person who has this condition; *kifafa* does not identify the person who has it. In the social domain the *kifafa* of a person and the person (him)herself are seen and treated separately; *kifafa* is feared, but the person having it is not. I suggested that the uncertainty around *kifafa* and the absence of stigma might be intertwined; fuzziness makes it not so easy for the aspects of stigma to unfold as there are no crisp notions of the norm and, subsequently, of what to consider the defiance from the norm.

I made an attempt at describing and analyzing the vast field of ideas around *kifafa* in Kigamboni; some of them were explicitly biomedical, some were related to the etiology constructed by *waganga*, and some were based on individual opinions. People usually had multiple interpretations of *kifafa*, sometimes even conflicting ones simultaneously. For those who wanted to receive a clear

answer about the etiology of this condition after reading this thesis there will probably be no satisfaction. I've given no clear answer because for the people of Kigamboni all the answers are valid; seeking for a single right one is neither problematized nor necessary.

Various pro-biomedical institutions trying to standardize *uganga*, reshape it, reduce the uncertainty around it, and to bring it under control, often produce the very phenomena they are fighting with. The idea of epilepsy-related stigma constructs *kifafa* both as a stigmatizing condition and as a strictly defined biomedical illness, which is misleading as my thesis demonstrates. As for *waganga*, they are interested in the uncertainty around *kifafa* so that their services as the providers of certainty stay in demand. The affliction itself remains fuzzy and ambiguous also due to the divination practice, which approaches *kifafa* as a set of conditions that vary for every particular client. The medical epistemology of Kigamboni does well without definite certainties allowing for plurality and possibility. The 'fog' of uncertainty surrounding *uganga* and *kifafa*, which might be confusing for some eyes, is the *sine qua non* condition of the healing epistemology in Kigamboni.

List of abbreviations

AAA	American Anthropological Association
AAS	Australian Anthropological Society
AIDS	Acquired Immunodeficiency Syndrome
CCM	<i>Chama cha Mapinduzi</i> , Party of the Revolution
CHAWATIATA	<i>Chama cha Waganga na Wakunga wa Tiba ya Asili Tanzania</i> or National Organization of Traditional Healers and Midwives in Tanzania
HIV	Human Immunodeficiency Virus
IBE	International Bureau for Epilepsy
ICT	Information and Communications Technology
ILAE	International League Against Epilepsy
IMF	International Monetary Fund
MSU	Moscow State University
NGO	Non-Governmental Organization
OAU	Organization of African Unity
RTCC	Russian-Tanzanian Cultural Centre
TANU	Tanganyika African National Union
UKIMWI	<i>Ukosefu wa kinga mwilini</i> , HIV/AIDS
UN	United Nations
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
WHO	World Health Organization

List of tables, maps, graphs and illustrations

Map 1. Kigamboni area (in yellow) and Dar es Salaam.....	28
Map 2. My daily route to research location.....	29
Table 1. Sub-questions and methods.....	31
Table 2. Four types of relation between, and transmission of, medical epistemologies.....	49
Cartoon by Fadhili Mohamed.....	52
Graph 1. Age and gender of the survey participants (%).....	56
Graph 2. Gender and the education levels of the survey participants (%).....	57
Graph 3. Gender and knowledge of the word ‘epilepsy’ of the survey participants (%).....	58
Graph 4. Gender, age and education level of the survey participants, who support the 1 st explanation (%).....	59
Graph 5. Gender, age and education level of the survey participants, who believe in the 2 nd explanation (%).....	59
Graph 6. Gender, age and education level of the survey participants, who support the 3 ^d explanation (%).....	60
Graph 7. Gender, age and education level of the survey participants, who support the 4th explanation (%).....	61
Graph 8. Gender, age and education level of the survey participants, who support the 5th explanation (%).....	62
Graph 9. Gender, age and education level of the survey participants, who support the 7th explanation (%).....	63
Graph 10. Gender, age and education level of the survey participants, who support the 8th explanation (%).....	64
Graph 11. Gender, age and education level of the survey participants, who support the 9th explanation (%).....	65
Graph 12. Gender, age and education level of the survey participants, who support the 11th explanation (%).....	66
Graph 13. Gender, age and education level of the survey participants, who would prefer biomedicine (%).....	89

Graph 14. Gender, age and education level of the survey participants, who said they would prefer traditional medicine (%).....	91
Mzee Ibla’s divination room.....	93
Herbs used by Mariam Kondo to treat <i>kifafa</i> and the <i>mganga</i> herself.....	96
Siwatu Hija in her red divination room.....	97
Graph 15. Gender, age and education level of the survey participants, who said <i>kifafa</i> was contagious (%).....	108
Graph 16. Gender, age and education level of the survey participants, who said <i>kifafa</i> was not contagious (%).....	109
Saidi Juma Udagila.....	110
Hamis Osman Hamis.....	112
Majuma Saidi.....	114
Pili and her <i>kifafa</i> id card.....	116

Glossary¹⁷

akili - mind

akili inapinduka - mind twists

alianguka - (s)he fell

alipata nafuu - (s)he got better

alipoteza akili - (s)he lost consciousness

amahomelo - war medicine used by the Ngoni

anakauka - (s)he becomes dry

ardhi - land

bajaji - tricycle that looks like an Indian rickshaw

banyani - banyan

bei nafuu - cheap price

biashara ndogo - small trade

bibi - Mrs.

chakula - food

choo - latrine

dalili ya uchawi - sign of witchcraft

dawa - medicine, pill, pl. '**madawa**'

degedege - convulsions

hatoi mapovu mdomoni - (s)he doesn't froth at the mouth

Hodi - May I come in?

homa kali - high fever

¹⁷ All the words are taken from Swahili unless specified otherwise

kanga - piece of cloth used in multiple ways

kanzu - male shirt

Karibu - Welcome

kazi ndogo - little job(s)

kichwa - head

kifafa - epilepsy

kifafa cha utoto - *kifafa* of childhood

kifafa hakiambukizi - *kifafa* is not contagious

kifua – tuberculosis, chest

kijakazi - slave girl, maid

kipindupindu - cholera

kipofu - blind person

kirihani - sweet basil

kisukari - diabetes

kitambulisho - id card

kivumbasi - lemon basil

kizunguzungu - dizziness

konyagi - strong Tanzanian alcoholic beverage

kuanguka - to fall

kujamba - to emit digestive gases from the anus

kujitegemea - self-reliance

kukakamaa - to strain muscles

kukojoa - to urinate

kupoteza fahamu - to lose consciousness

kurithi - to inherit

kurogwa - to be bewitched

kutafuna meno na ulimi - to bite teeth and the tongue

kutapika – nausea, to vomit

kutetemeka - to tremble, to twitch

kutingisha mikono na miguu - to shake hands and feet

kutoa mapovu mdomoni - to have foam in the mouth

kutoka pwani - from the coast

kuvunja mwiko - to break a taboo

kuzaliwa nao - born with it, inborn condition

kuzimia - to faint

kwanza degedege baadaye kifafa - first *degedege*, then *kifafa*

macho yanajitokeza - protruding eyes

macho yenye sumu - poisonous eyes

maduka – shops, sing. ‘*duka*’

maendeleo - development

majeraha ya kujifungua - birth injury

maji - water

majini – genies, sing. ‘*jini*’

mambo ya uchawi - witchcraft business

mapepo – demons, sing. ‘*pepo*’

mapesa mengi kwa madaktari - doctors demand a lot of money

mashetani – demons, sing. '***shetani***'

matapishi - vomit

mavi ya tembo - elephant dung

mazingira - environment

mbuyu - baobab

mchanga kwenye tumbo - sand in the stomach

mchawi - witch, sorcerer, pl. '***wachawi***'

mdimu - lime tree

mdudu - witch, sorcerer, pl. '***wadudu***'

mganga - healing practitioner, pl. '***waganga***'

mganga wa kienyeji - traditional healer

mitishamba - herbs

mkeka - mat

mkizi - cuttlefish

mkoji - urine

mkundekunde - legumes

Msikiti wa Jangwani - Jangwani Mosque

mwalimu - teacher

mwegea - sausage tree

mzalianyuma - spurge

mzimu – spirit, pl. '***wazimu***'

mzungu - white person, pl. '***wazungu***'

ndege – bird, plane

Pole sana - So sorry for that

polepole ndio mwendo - slow and steady wins the race

pwani - coast

ramli - divination

shtuko la tumbo - stomach upset

siasa safi - good policy

subili - aloe

tumbo - stomach

ubongo - brain

uchawi - witchcraft

uganga - healing

uganga wa jini/shetani - healing with the help of spirits

uganga wa kitabu - healing by a book

uganga wa korani - healing by the Quran

uganga wa miti shamba - herbalism

uganga wa ngoma - healing with music and sounds

ugonjwa wa kitoto - childhood illness

ugonjwa wa kuanguka - falling sickness

ugonjwa wa kurithi - hereditary illness

ujamaa - socialism

ukosefu wa kinga - deficit of immunity

uongozi bora - good governance

upepo - wind

usafi - hygiene, cleanness

utoaji mimba - abortion

uzazi - childbirth

wakunga – midwives, sing. **'mkunga'**

wapagazi – porters, sing. **'mpagazi'**

watu – people, sing. **'mtu'**

Appendix

The semi-structured questionnaire

1. Name (Jina) _____
2. Age (Umri) _____
3. Gender (Jinsia) _____
4. Occupation (Kazi) _____
5. Education (primary school/secondary school/university degree/none)

Kiwango cha elimu (shule ya msingi/shule ya sekondari/chuo kikuu/hamna)

6. What is kifafa? How do you understand that a person has this particular illness and not another one? (Kifafa maana yake nini? Namna gani unafahamu kwamba mtu fulani ana ugonjwa huohuo na si ugonjwa mwingine?)

7. Do you know anyone who has kifafa? (Unawajua watu wo wote walio na ugonjwa huo wa kifafa?)

8. If you do, what is your relation to them? (family/friends/colleagues, etc. or I know nobody that has this illness)

Ukimjua mtu aliye na kifafa, ana uhusiano gani nawe? (anatoka ukoo wangu/rafiki yangu/tunafanya kazi pamoja, n.k. au Mimi sijui mtu aliye na ugonjwa huo)

9. Do you know what 'epilepsy' is? Is it the same as kifafa? (Unajua 'epilepsy' maana yake nini? Je, linamaanisha kitu sawasawa na kifafa?)

10. Please, give a list of illnesses you know (Tafadhali, uandike majina ya magonjwa unayoyajua)

11. What do you think are the causes of kifafa? (Unafikiri kifafa kinasababishwa na nini?)

12. Is kifafa contagious? If yes, how does one get it? (Je, kifafa kinaambukiza? Kama ndiyo, namna gani?)

13. If you or your relative had kifafa, would you first go to a traditional healer or a doctor? Why? (Yamkini wewe au ndugu yako ana kifafa. Utakwenda kwanza kwa mganga wa kienyeji au kwa daktari wa hospitalini? Kwa sababu gani?)

Bibliography

- Ademuwagun, Z. A., J. Ayoade, J. Harrison, and D. M. Warren, (eds.). (1978). *African Therapeutic Systems*. Waltham, Mass.: Crossroads Press
- Ahearn, L. M. (2001). Language and Agency. In *Annual Review of Anthropology* 30: 109-137
- Alonzo, A. & Reynolds, N. (1995). Stigma, HIV and AIDS: An Exploration and Elaboration of a Stigma Trajectory. In *Soc. Sci. Med.* 41 (3): 303-315
- Amuri, M. et al. (2011). Socio-economic status and HIV/AIDS stigma in Tanzania. In *AIDS Care* 23(3): 378-382
- Andermahr, S. (1997). Agency. In S. Andermahr (ed.) *A Concise Glossary of Feminist Theory*, , New York: Arnold: 11-12
- Andermann, L. (1995). Epilepsy in developing countries. In *Transcultural Psychiatry Research Review* 32: 351-84
- Andermann, L. (2000). Epilepsy in Our World: An Ethnographic View. In *Epilepsy & Behavior* 1: 169-175
- Barker, Chris. (2005). *Cultural Studies: Theory and Practice*. London: Sage
- Barringer, Tim. (1996). Fabricating Africa: Livingstone and the Visual Image, 1850-1874. In *David Livingstone and the Victorian Encounter with Africa*: 169-197. London: National Portrait Gallery
- Benite, Z. (2011). Modernity: the Sphinx and the Historian. In *American Historical Review* 116 (3): 638-652
- Berbrier, M. (2002). Making Minorities: Cultural space, stigma transformation frames, and the categorical status claims of deaf, gay, and white supremacist activists in late twentieth century America. In *Sociological Forum* 17: 553-591
- Bernard, R. H. (2011). *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. - 5th ed. Lanham: AltaMira Press
- Bleek, W. (1987). Lying Informants: A field experience from Ghana. In *Population and Development Review* 13(2): 314-322
- Borchgrevink, A. (2003). Silencing Language: Of Anthropologists and Interpreters. In *Ethnography* 4: 95-122
- Bourdieu, Pierre. (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press
- Brock, B. (1966). The Nyiha of Mbozi. In *Tanzania Notes and Records* 65: 1-30
- Burton, R. F. (1860). *The Lake Regions of Central Africa*. New York

- Campbell, C. et al. (2007). 'Dying Twice': A Multi-level Model of the Roots of AIDS Stigma in Two South African Communities. In *Journal of Health Psychology* 12(3): 403-416
- Castle, S. E. (1994). The (Re)Negotiation of Illness Diagnosis and Responsibility for Child Death in Rural Mali. In *Medical Anthropology Quarterly* 8(3): 314–335
- Comaroff, Jean & John L. Comaroff. (1993). *Modernity and its malcontents: ritual and power in Postcolonial Africa*. Chicago: University of Chicago Press
- Comoro, C., Nsimba, S. E. D., Warsame, M., Tomson, G. (2003). Local Understanding, Perceptions and Reported Practices of Mothers/Guardians and Health Workers on Childhood Malaria in a Tanzanian District – Implications for Malaria Control. In *Acta Tropica* 87: 305-313
- Cooper, F. (2005). *Colonialism in Question: Theory, Knowledge, History*. Berkeley, Calif.
- Crocker, J. & Lutskey, N. (1986). Stigma and the dynamics of social cognition. In *The Dilemma of Difference*, S. C. Ainley, G. Becker, L. M. Coleman (eds.). New York: Plenum
- Cummings, T. (2011). ORPHANS stories. Kindle Edition
- Davidson D. (1980[1971]). Agency. In *Essays on Actions and Events*, ed. D Davidson, Oxford: Clarendon Press: 43-61
- Davies, B. (1991). The concept of agency: a feminist poststructuralist analysis. *Soc. Anal.* 30: 42-53
- Deacon, H. (2006). Towards a Sustainable Theory of Health-Related Stigma: Lessons from the HIV/AIDS Literature. In *Journal of Community & Applied Social Psychology* 16: 418-425
- de Bruijn, M., Rijk van Dijk & Jan-Bart Gewald, eds. (2007). *Strength beyond Structure. Social and Historical Trajectories of Agency in Africa*. Leiden: Brill
- de Bruijn, M. and van Dijk, R. (2012). Connecting and Change in African Societies: Examples of "Ethnographies of Linking" in Anthropology. In *Anthropologica* 54: 45-59
- Devisch, Rene. (1993). *Weaving the Threads of Life*. Chicago: University of Chicago.
- de Savigny, D. et al. (2004). Care-Seeking Patterns for Fatal Malaria in Tanzania. In *Malaria Journal* 3 (27): 1-15
- Dillip, A. et al. (2012). Acceptability – a Neglected Dimension of Access to Health Care: Findings from a Study on Childhood Convulsions in Rural Tanzania. In *BMC Health Services Research* 12 (113): 1-11
- Dissanayake, W., (ed.). (1996). *Narratives of Agency: Self-Making in China, India, and Japan*. Minneapolis: Univ. Minn. Press
- Donohoe, M. (2003). Causes and health consequences of environmental degradation and social injustice. *Soc. Sci. Med.* 56: 573–587
- Dubois, D. & Prade, H. (1980). *Fuzzy Sets and Systems: Theory and Applications*. New York: Academic Press

- Du Toit, Brian, and I. Abdallah, eds. (1985). *African Healing Systems*. New York: Trado-Medic Books
- Ebner, E. (1987). *The History of Wangoni – and their Origin in the South African Bantu Tribes*. Peramiho: Benedictine Publications
- Ebrahim, G. J. (1983). *Nutrition in Mother and Child Health*. London: Macmillan
- Erdtsieck, Jessica. (2003). *In the Spirit of Uganga. Inspired Healing and Healership in Tanzania*. Amsterdam: AGIDS
- Escobar, G. J. et al. (1983). Beliefs Regarding the Etiology and Treatment of Infantile Diarrhea in Lima, Peru. In *Social Science and Medicine* 17 (17):1257-1269
- Feierman, S. (1985). Struggles for Control. The Social Roots of Health and Healing in Modern Africa. In *African Studies Review*, 28 (2/3): 73-147
- Feierman, S. (1986). Popular Control over the Institutions of Health: A Historical Study. In M. Last & G. Chavunduka (eds.) *The Professionalization of African Medicine*. Manchester: Manchester University Press and the International African Institute: 205-218
- Feierman, S. & J. M. Janzen (eds.). (1992). *The Social Basis of Health and Healing in Africa*. Berkeley: University of California Press
- Feierman, S. (2008). Money heals: traditional medicine and the meanings of exchange. In *Palabres Actuelles* (2): 5-26
- Ferguson, James. (1999). *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt*. Berkeley: University of California Press
- Finch, H. & J. Lewis. (2003). Focus Groups. In J. Ritchie & J. Lewis (eds.) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London, Sage: 170-198
- Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. New York: Pantheon
- Foucault, M. (1978). *The History of Sexuality*, Vols. 1, 2. New York: Pantheon
- Gardiner, J. K. (ed.). (1995). *Provoking Agents: Gender and Agency in Theory and Practice*. Urbana: Univ. Illinois Press
- Geest, Sjaak van der. (1997). Is There a Role for Traditional Medicine in Basic Health Services in Africa? A Plea for Community Perspective. In *Tropical Medicine and International Health* 2 (9): 903-911
- Geschiere, P. (1997). *The modernity of witchcraft: politics and the occult in postcolonial Africa*. Charlottesville, VA: University Press of Virginia
- Gessler, M. C. et al. (1995). Traditional Healers in Tanzania: The Perception of Malaria and Its Causes. In *Journal of Ethnopharmacology* 48: 119–130

- Giel, R. (1968). The Epileptic Outcast. In *East African Medicine Journal* 45(1): 27–31
- Giles, Linda L. (1987). Possession Cults on the Swahili Coast: A Re-examination of the Theories of Marginality. In *Africa* 57 (2): 234-258
- Giles, Linda L. (1999). Spirit Possession and the Symbolic Construction of Swahili Society. In *Spirit Possession, Modernity, and Power in Africa*, ed. Heike Behrend and Ute Luig, 142-164. Oxford: James Currey
- Gluckman, M. (1941). *Economy of the Central Barotse Plain*. RLI Paper No. 7. Livingstone: RLI
- Gluckman, M. (1951). The Lozi of the Barotseland in north-western Rhodesia. In *E. Colson & M. Gluckman (eds.) Seven Tribes of Central Africa*. London: Oxford University Press for RLI
- Gluckman, M. (1954). *The Judicial Process among the Barotse of Northern Rhodesia*. Manchester: Manchester University Press for RLI
- Goddard, V. A., (ed.). (2000). *Gender, Agency and Change: Anthropological Perspectives*. New York: Routledge
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall
- Громова Н. В. (Gromova, N.) (1995). Теоретическая грамматика языка суахили (*Theoretical Grammar of the Swahili Language*). Москва: Наследие (Moscow: Naslediye)
- Haram, L. & Yamba, C. B. (2009). Situating Uncertainty in Contemporary Africa: An Introduction. In *L. Haram & C. B. Yamba (eds.) Dealing with Uncertainty in Contemporary African Lives*. Nordiska Afrikainstitutet, Stockholm: 11-28
- Harvey, D. (2005). *A Brief History of Neoliberalism*. Oxford: Oxford University Press
- Hausmann Muela, S. et al. (2002). Medical Syncretism with Reference to Malaria in a Tanzanian Community. In *Social Science and Medicine* 55: 403–413
- Helman, Cecil G. (2007). *Culture, Health and Illness. Fifth Edition*. London: Hodder Education
- Holzemer, W. et al. (2007). A conceptual model of HIV/AIDS stigma from five African countries. In *Journal of Advanced Nursing* 58 (6): 541-551
- Hunter, E., Rogathi, J., Chigudu, S., Jusabani, A., Jackson, M., McNally, R., Gray, W., Whittaker, R. G., Iqbal, A., Birchall, D., Aris, E., Walker, R. (2012). Prevalence of Active Epilepsy in Rural Tanzania: a Large Community-Based Survey in an Adult Population. In *Seizure* 21: 691-698
- Iliffe, J. (1979). *A Modern History of Tanganyika*. African Studies Series, no 25. Cambridge: Cambridge University Press
- Jacobson-Widding, A. and Westerlund, D. (eds.). (1989). *Culture, Experience and Pluralism. Essays on African Ideas of Illness and Healing*. Uppsala
- Janzen, John M. (1982). *Lemba, 1650-1930: A Drum of Affliction in Africa and the New World*. New York: Garland

- Jenkins, R., Jessen, H. & V. Steffen (eds.). (2005a). *Managing Uncertainty: Ethnographic Studies of Illness, Risk and the Struggle for Control*. Copenhagen: Museum Tusulanum press, University of Copenhagen
- Jenkins, R., Jessen, H. & V. Steffen. (2005b). Matters of Life and Death: The Control of Uncertainty and the Uncertainty of Control (Ch. 1). In *Managing Uncertainty: Ethnographic Studies of Illness, Risk and the Struggle for Control*. Copenhagen: Museum Tusulanum press, University of Copenhagen: 9-30
- Jilek, W. G. (1979). The epileptic outcast role and its background: a contribution to the social psychiatry of seizure disorders. In *Journal of Operational Psychiatry* 10(2): 128 –133
- Johannessen, H. & E. Lázár, eds. (2006). *Multiple medical realities: Patients and healers in biomedical, alternative and traditional medicine*. Oxford: Berghahn
- Jones, E.; Farina, A.; Hastorf, A.; Markus, H.; Miller, D. T.; Scott, R. (1984). *Social Stigma: The Psychology of Marked Relationships*. New York: Freeman
- Kamat, V. R. (2006). "I Thought It Was only an Ordinary Fever!" Cultural Knowledge and the Micropolitics of Therapy Seeking for Childhood Febrile Illness in Tanzania. In *Social Science and Medicine* 62(12): 2945–2959
- Kamat, V. R. (2008a). Dying under the Bird's Shadow. Narrative Representations of *Degegede* and Child Survival among the Zaramo of Tanzania. In *Medical Anthropology Quarterly* 22 (1): 67-93
- Kamat, V. R. (2008b). Reconsidering the Allure of the Culturally Distant in Therapy Seeking: A Case Study from Coastal Tanzania. In *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 27 (2): 106-135
- Katz, S. and Kimani, V. (1982). Why patients go to the traditional healers. In *East African Medical Journal* 59 (3): 170-174
- Kaufmann, A. (1975). *Introduction to the Theory of Fuzzy Subsets*. New York: Academic Press
- Kawachi, I., Kennedy B.P., Wilkinson R.G. (eds). (1999). *Income Inequality and Health: The Society and Population Health Reader, Volume 1*. New York: New Press
- Kendall-Taylor, N. (2008). Traditional Healers and Epilepsy Treatment on the Kenyan Coast. In *Epilepsia* 49 (9): 1638-1639
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. Berkeley: University of California Press
- Klir, G. J. & T. A. Folger. (1988). *Fuzzy Sets, Uncertainty, and Information*. Englewood Cliffs, NJ: Prentice-Hall
- Knight, C. (1974). *Ecology and Change – Rural modernization in an African community*. N. Y.: Academic Press

- Kreuger, R.A. & M.A. Casey. (2000). *Focus Groups: A Practical Guide for Applied Research*. 3d edition. Thousand Oaks, CA: Sage
- Kumar, N., (ed.). (1994). *Women as Subjects: South Asian Histories*. Charlottesville: Univ. Virginia Press
- Langwick, Stacey A. (2007). Devils, Parasites and Fierce Needles: Healing and the Politics of Translation in Southern Tanzania. In *Science, Technology, & Human Values* 32 (1): 88-117
- Langwick, Stacey A. (2008). Articulate(d) bodies: Traditional medicine in a Tanzanian hospital. In *American Ethnologist* 35 (3): 428-439
- Langwick, Stacey A. (2011). *Bodies, Politics, and African Healing. The Matter of Maladies in Tanzania*. Indiana University Press, Bloomington
- Laughlin, C. D. (1993). Fuzziness and Phenomenology in Ethnological Research: Insights from Fuzzy Set Theory. In *Journal of Anthropological Research* 49(1): 17-37
- Lee, R. B. (1990). Eating Christmas in the Kalahari. In *Hunter, P. W. a. D. (ed) Anthropology: Contemporary Perspectives*. New York, Harper Collins
- Leshari, M. (1984). Traditional and modern medicine – Is a marriage possible? In *World Health Forum* 5: 175-177
- Link, B. G. and Phelan, J. C. (1999). Labeling and stigma. In *The Handbook of the Sociology of Mental Health*, C. S. Aneshensel & J. C. Phelan (eds.). New York: Plenum
- Link, B. G. and Phelan, J. C. (2001). Conceptualizing Stigma. In *Annual Review of Sociology* 27: 363-385
- Luedke, T. J. and West, H. G., eds. (2006). *Borders and Healers. Brokering Therapeutic Resources in Southeast Africa*. Indiana University Press
- Makemba, A. M. et al. (1996). Treatment Practices for *Degegede*, a Locally Recognized Febrile Illness, and Implications for Strategies to Decrease Mortality from Severe Malaria in Bagamoyo District, Tanzania. In *Tropical Medicine & International Health* 1 (3): 305-313
- Matuja, W. B. P. et al. (2001). Risk Factors for Epilepsy in a Rural Area in Tanzania: a Community-Based Case-Control Study. In *Neuroepidemiology* 20: 242-247
- McNay, L. (2000). *Gender and Agency: Reconfiguring the Subject in Feminist and Social Theory*. Oxford, UK: Blackwell
- Mesaki, S. (1998). *The changing role of Traditional Medicine and Healing in Dar es Salaam: 1970's-1990's*. Dar es Salaam: SAREC report of the Sociology Department University of Dar es Salaam
- Mesaki, S. (2009). Witchcraft and the law in Tanzania. In *International Journal of Sociology and Anthropology* 1(8): 132-138
- Mills, M. B. (2003). Gender and Inequality in the Global Labor Force. In *Annual Review of Anthropology* 32: 41-62

- Mitchell, C. (1956). *Kalela dance: aspects of social relationships among urban Africans in Northern Rhodesia*. Manchester University Press
- Moore, H. L. & T. Sanders. (2001). *Magical interpretations, material realities: modernity, witchcraft, and the occult in postcolonial Africa*. London: Routledge
- Morgan, D.L. (1988). *Focus Groups as Qualitative Research*. Thousand Oaks: CA: Sage
- Morley, D. C. (1973). *Pediatric Priorities in the Developing World*. London: Butterworth
- Moshi, M. J. et al. (2005). Plants Used to Treat Epilepsy by Tanzanian Traditional Healers. In *Journal of Ethnopharmacology* 97: 327-336
- Mushi, D. (2011). Social-Cultural Aspects of Epilepsy in Kilimanjaro Region, Tanzania: Knowledge and Experience among Patients and Carers. In *Epilepsy & Behavior* 20 (2): 338-343
- Nguyen, V-K & Peschard, K. (2003). Anthropology, Inequality, and Disease: A Review. In *Annual Review of Anthropology* 32: 447-474
- Niehaus, I. (2007). Death before Dying: Understanding AIDS Stigma in the South African Lowveld. In *Journal of South African Studies* 33(4): 845-860
- Nsimba, S. E. D. & Kayombo, E. J. (2008). Sociocultural Barriers and Malaria Health Care in Tanzania. In *Evaluation & Health Professions* 31 (3): 318-322
- Odimegwu, C. et al. (2013). HIV/AIDS stigma and utilization of voluntary counselling and testing in Nigeria. In *BMC Public Health* 13(465): 1-14
- Ojanuga, D. (1981). What doctors think of Traditional healers – and visa versa. In *World Health Forum* 2 (3): 407-410
- Okello Ayot, H. (1976). *Topics in East-African History*. Nairobi/Dar es Salaam: E. A. Literature Bureau
- Pels, P. (1999). *A Politics of Presence. Contacts between Missionaries and Waluguru in Late Colonial Tanganyika*. Harwood Academic Publishers
- Pels, P. (2003). Introduction: Magic and Modernity. In Meyer, B. & Pels, P. (eds.) *Magic and Modernity: Interfaces of Revelation and Concealment*. Stanford, CA : Stanford University Press: 1-38
- Pigg, S. L. (1996). The Credible and the Credulous: The Question of 'Villagers' Beliefs' in Nepal. In *Cultural Anthropology* 11 (2): 160-201
- Plummer, M. et al. (2008). Aborting and Suspending Pregnancy in Rural Tanzania: An Ethnography of Young People's Beliefs and Practices. In *Studies in Family Planning* 39 (4): 281-292
- Pool, R. (1986). Beliefs Concerning the Avoidance of Food during Pregnancy and the Immediate Post-Partum Period in a Tribal Area of Rural Gujarat, India. In *Eastern Anthropologist* 39 (3): 251-259
- Pool, R. (1987a). Hot and Cold as an Explanatory Model: The Example of Bharuch District in Gujarat, India. In *Social Science and Medicine* 25(4): 389-399

- Pool, R. (1987b). Hot-cold Beliefs during Pregnancy: The Case of the Bhils in Gujarat. In *Journal of Research and Education in Indian Medicine* 4(3-4): 53-57
- Pool, R. (1989). *There must have been something...Interpretations of Illness and Misfortune in a Cameroon Village*. Amsterdam
- Ranger, T. (1966). *Witch-Craft eradication movements in Central and Southern Tanzania and their connection with the Maji Maji rising. History Seminar Paper*. Dar es Salaam: University of Dar es Salaam
- Read, M. (1970). *The Ngoni of Nyasaland*. London: Frank Cass & Co
- Reis, R. (1994). Evil in the Body, Disorder of the Brain: Interpretations of Epilepsy and the Treatment Gap in Swaziland. In *Tropical and Geographical Medicine* 46: S40-43
- Reis, R. (2000). The 'wounded healer' as ideology: The work of ngoma in Swaziland. In *Rijk van Dijk, Ria Reis & Marja Spierenburg (eds.) The Quest for Fruiton through Ngoma. The Political Aspects of Healing in Southern Africa*. London: Villiers Publications: 61-75
- Reis, R. & Meinardi, H. (2002). ILAE/WHO "Out of the Shadows Campaign". Stigma: Does the Flag Identify the Cargo? In *Epilepsy and Behavior* 3: 33-37
- Rockel, Stephen J. (2000). 'A Nation of Porters': The Nyamwezi and the Labour Market in Nineteenth-Century Tanzania. In *Journal of African History* 41: 173-195
- Roura, M., Wringe, A., Busza, J., Nhandi, B., Mbata, D., Zaba, B., & Urassa, M. (2009). "Just like fever": A qualitative study on the impact of antiretroviral provision on the normalisation of HIV in rural Tanzania and its implications for prevention. In *BMC International Health and Human Rights*, 9 (22). doi:10.1186/1472-698X-9-22
- Rovane, C. (1998). *The Bounds of Agency: An Essay in Revisionary Metaphysics*. Princeton, NJ: Princeton Univ. Press
- Rwiza, H. T. et al. (1993a). The Clinical and Social Characteristics of Epileptic Patients in Ulanga District, Tanzania. In *Epilepsy* 6: 162-169
- Rwiza, H. T. et al. (1993b). Knowledge, Attitude, and Practice Toward Epilepsy Among Rural Tanzanian Residents. In *Epilepsia* 34 (6): 1017-1023
- Sanders, T. (2000). Rains Gone Bad, Women Gone Mad: Rethinking Gender Rituals of Rebellion and Patriarchy Author(s). In *The Journal of the Royal Anthropological Institute* 6 (3): 469-486
- Sanders, T. (2001). Save Our Skins: Structural Adjustment, Morality and the Occult in Tanzania. In *Henrietta L. Moore & Todd Sanders (eds) Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*. London and New York: Routledge: 160-183
- Sanders, T. (2002). Reflections on Two Sticks: Gender, Sexuality and Rainmaking. In *Cahiers d'Études Africaines* 42 (166): 285-313

- Sanders, T. (2003). Reconsidering Witchcraft: Postcolonial Africa and Analytic (Un)Certainties. In *American Anthropologist, New Series* 105 (2): 338-352
- Sanders, T. (2009). Invisible Hands and Visible Goods: Revealed and Concealed Economies in Millennial Tanzania (Ch. 4). In L. Haram & C. B. Yamba (eds.) *Dealing with Uncertainty in Contemporary African Lives*. Nordiska Afrikainstitutet, Stockholm: 91-117
- Scott, J. C. (1998). *Seeing like a state: How certain schemes to improve the human condition have failed*. New Haven: Yale University Press
- Segal, J. M. (1991). *Agency and Alienation: A Theory of Human Presence*. Savage, MD: Rowman Littlefield
- Slikkerveer, L. (1982). Rural health development in Ethiopia: Problems in utilization of traditional healers. In *Social Science & Medicine* 14 (21): 1859-1872
- Smithson, M. (1987). *Fuzzy Set Analysis for Behavioral and Social Sciences*. New-York: Springer-Verlag
- Speke, J. H. (1864). *Journal of the Discovery of the Source of the Nile*. New York
- Stafford, M. C. & Scott, R. R. (1986). Stigma deviance and social control: some conceptual issues. In *The Dilemma of Difference*, S. C. Ainley, G. Becker, L. M. Coleman (eds.). New York: Plenum
- Stroeken, Koen. (2010). Moral power: the magic of witchcraft. In *Epistemologies of Healing* Vol. 9. Berghahn Books, New York, Oxford
- Stroeken, Koen. (2012). Health care decisions by Sukuma 'peasant intellectuals': a case of radical empiricism? In *Anthropology & Medicine* 19 (1): 119-128
- Swantz, L. (1990). *The Medicine Man among the Zaramo of Dar es Salaam*. Uppsala: The Scandinavian Institute of African Studies in cooperation with Dar es Salaam University Press
- Tarimo, D. S. et al. (2000). Mothers' Perceptions and Knowledge of Childhood Malaria in the Holoendemic Kibaha District, Tanzania: Implications for Malaria Control and the IMCI Strategy. In *Tropical Medicine and International Health* 5(3): 179-184
- The Qur'an. Translated by Abdullah Yusuf Ali
- Tindall, P. (1985). *History of Central Africa*. Blantyre, Malawi: Dzuka Publishing Company
- Toren, C. & J. de Pina-Cabral. (2011). Introduction: The Challenge of Epistemology. In C. Toren & J. de Pina-Cabral (eds.) *The Challenge of Epistemology: Anthropological Perspectives*. New York: Berghahn Books: 1-18
- Turner, Victor. (1967). *The Forest of Symbols: Aspects of Ndembu Ritual*. Ithaca, N. Y.: Cornell University Press
- Turner, Victor. (1968). *The Drums of Affliction: A Study of Religious Processes among the Ndembu of Zambia*. Oxford: Clarendon Press

- Turner, Victor. (1975). *Revelation and Divination in Ndembu Ritual*. Ithaca, N. Y.: Cornell University Press
- van Dijk, Rijk et al., eds. (2000). *The Quest for Fruiton through Ngoma. The Political Aspects of Healing in Southern Africa*. London: Villiers Publications
- van Dijk, Rijk. (2007). The safe and suffering body in transnational Ghanaian Pentecostalism: Towards an anthropology of vulnerable agency. In *M.de Bruijn, Rijk van Dijk & Jan-Bart Gewald (eds.) Strength beyond Structure. Social and Historical Trajectories of Agency in Africa*. Leiden: Brill: 312-333
- Wandel, M. et al. (1984). Heaty and Cooling Foods in Relation to Food Habits in a Southern Sri Lanka Community. In *Ecology of Food and Nutrition* 14:93-104
- Whyte, S. Reynolds. (1997). *Questioning Misfortune: the Pragmatics of Uncertainty in Eastern Uganda*. V 4, Cambridge: Cambridge University Press
- Wilkinson, R. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, UK: Routledge
- Winch, P. J. et al. (1996). Local Terminology for Febrile Illnesses in Bagamoyo District, Tanzania, and Its Impact on the Design of a Community-Based Malaria Control Programme. In *Social Science and Medicine* 42(7): 1057–1067
- Winkler, Andrea S. et al. (2009). Prevalence, Incidence, and Clinical Characteristics of Epilepsy – A Community-Based Door-to-Door Study in Northern Tanzania. In *Epilepsy & Behavior* 19 (4): 596-601
- Winkler, Andrea S. et al. (2010a). Attitudes Towards African Traditional Medicine and Christian Spiritual Healing Regarding Treatment of Epilepsy in Rural Community of Northern Tanzania. In *Afr. J. Trad. CAM* 7 (2): 162-170
- Winkler, Andrea S. et al. (2010b). Belief Systems of Epilepsy and Attitudes towards People Living with Epilepsy in a Rural Community of Northern Tanzania. In *Epilepsia* 50 (10): 2310-2313
- Winkler, Andrea S. et al. (2012). Measuring the Epilepsy Treatment Gap in Sub-Saharan Africa. In *Lancet Neurology* 11 (8): 655-657
- Woodside, A. (2006). *Lost modernities: China, Vietnam, Korea, and the hazards of world history*. Cambridge: Harvard University Press
- Yager, R. R., S. Ovchinnikov, R. M. Tong & H. T. Nguyen. (1987). *Fuzzy Sets and Applications: Selected Papers by L. A. Zadeh*. New York: Wiley
- Zadeh, L. A. (1965). *Fuzzy Sets. Information and Control* 8:338-353 [reprinted in Yager et al, 1987]
- Zadeh, L. A. (1975). Calculus of Fuzzy Restrictions. In *L. A. Zadeh, K.-S. Fu, K. Tanaka & M. Shimura (eds.) Fuzzy Sets and Their Applications to Cognitive and Decision Processes*. New-York: Academic Press: 1-39
- Zimmermann, H.-J. (1991). *Fuzzy Set Theory and Its Applications*. Boston: Kluwer
- AAA Code of Ethics (1998):

<http://www.aaanet.org/committees/ethics/ethcode.htm> (Accessed on March 11, 2012)

AAS Code of Ethics (2003):

www.aas.asn.au/docs/AAS_Code_of_Ethics.pdf (Accessed on March 11, 2012)

BBC News. (July 24, 2008). Vicky Ntetema. In hiding for exposing Tanzania witchdoctors:

<http://news.bbc.co.uk/2/hi/africa/7523796.stm> (Accessed on October 12, 2012)

BBC News. (February 23, 2012). Tanzania police arrested over 'witchcraft killing' riot:

<http://www.bbc.co.uk/news/world-africa-17138958> (Accessed on February 23, 2012)

Fadhili Mohamed. Cartoons: <http://kabwelacomix.blogspot.com>

Hicks, R. (2009). Understanding Epilepsy. In *BBC Health*:

http://www.bbc.co.uk/health/physical_health/conditions/in_depth/epilepsy/epilepsy1.shtml
(Retrieved on 22 May 2012)

Jilek-Aall, L. (2010). Summarizing Report, Mahenge Epilepsy Clinic:

<http://mahenge.wordpress.com/about/mahenge-epilepsy-clinic/> (Retrieved on February 20, 2013)

Mapuri, Omar R. JEE, TUMEACHANA NA SIASA YA UJAMAA NA KUJITEGEMEA? LA HASHA. Siasa ya Kujitegemea. *Official web-site of CCM*: <http://www.ccmtz.org/makala/tumeachanamapuri.htm>
(Accessed on September 9, 2012)

Muhimbili University of Health and Allied Sciences (MUHAS):

www.muhas.ac.tz/index.php?option=com_content&task=view&id=39&Itemid=57 (Accessed on October 15, 2012)

Sacmeq. (2011). Policy Brief: Quality of Primary School Inputs in Tanzania Mainland. In *Southern and Eastern Africa Consortium for Monitoring Educational Quality*:

http://www.sacmeq.org/downloads/School%20inputs/TAN_School_Inputs_15Oct2011_FINAL.pdf
(Accessed on April 24, 2013)

The Guardian. (November 4, 2008). George Obulutsa. Albinos live in fear after body part murders:

<http://www.guardian.co.uk/world/2008/nov/04/tanzania-albinos-murder-witchcraft> (Accessed on October 15, 2012)

The World Health Organization. (2009). *Epilepsy*:

<http://www.who.int/mediacentre/factsheets/fs999/en> (Accessed on May 22, 2012)

The World Health Organization. (2012). *United Republic of Tanzania*:

<http://www.afro.who.int/en/tanzania/united-republic-of-tanzania.html> (Accessed on April 13, 2013)

The World Health Organization. (2000). *Traditional Medicine*:

<http://www.who.int/medicines/areas/traditional/definitions/en/index.html> (Accessed on March 25, 2013)

2002 Population and Housing Census General Report" (in en). Government of Tanzania.

[http://web.archive.org/web/20080427001338/http://www.tanzania.go.tz/census/census/districts/te
meke.htm](http://web.archive.org/web/20080427001338/http://www.tanzania.go.tz/census/census/districts/te
meke.htm) (Accessed on September 7, 2012)