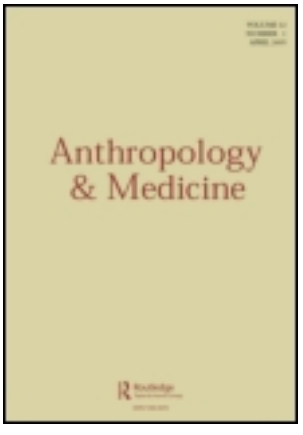

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Health care decisions by Sukuma 'peasant intellectuals': a case of radical empiricism?

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Health care decisions in Sukuma-speaking rural communities in Tanzania reproduce a practical epistemology that could be described as radically empiricist, rather than just pluralist; their point of reference is the deeper 'relation' between events, which collective traditions articulate and subjects may experience, but which escapes the atomistic perception privileged by biomedicine. This analysis relies on a diverse portfolio of ethnographic data, including the use and structure of medicinal recipes, the choices of mental health care according to experienced 'effectiveness', and lay discussions on the correct aetiology and treatment of reproductive disorder. Combining two dimensions for a given medical epistemology, the (empirical/ habitual) basis of its transmission and the (open/closed) relation with other epistemologies, four types are proposed: monism, dualism, pluralism, and radical empiricism. The concept of peasant intellectuals, it is argued, needs to be rethought in contexts of medicinal initiation.

Keywords: traditional medicine; ethnopharmacology; mental health; Sukuma; epistemology

Feierman (1990, 18) was inspired by Gramsci when he used the term 'peasant intellectuals' to acknowledge the creative intellectual activity and the actual organization of political movement by a select group of rural inhabitants in Tanzania, who at the brink of Independence shaped the country's future by making use of their social position at the nexus between (colonial) domination and (rural) public discourse. This term is adopted here, yet with an important re-orientation to the life-world of Sukuma farmers, the largest peasant group of Tanzania (which Feierman briefly mentioned in his book). Peasant intellectuals are not a select group in Sukuma communities, because the system of decision-making is polycentric and consensual: rather than the government, the village or a majority of individuals, all extended families usually decide together, with each adult representing the family (*kaya*). In Sukuma postcolonial history, 'power' and 'intellectual' refer less to political influence than to medicinal and divinatory knowledge acquired by joining one or more initiatory systems, including new traditions developed by upcoming healers.

The widespread presence of such medicinally aware peasants in Tanzania can explain a recent counterintuitive finding by Mshana et al. (2008, 35). They observed that in urban Dar Es Salaam an affliction such as stroke 'was widely believed to emanate from supernatural causes (demons and witchcraft), while in rural Hai,

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explanations drew mostly on ''natural'' causes (hypertension, fatty foods, stress).' Contrary to conventional wisdom, the farmers thus seem to entertain an empirically more sound position. The reason, as concluded from the author's fieldwork in Tanzanian villages, is that farmers have more experience with the production of medicine, in both making diagnoses and administering plant recipes. From adolescence, men and women learn to put the effectiveness of 'magic' into perspective. For example, although Sukuma-speaking villages are today witnessing the dwindling of traditions, many adults have in their youth undergone a medicinal initiation called *ihane*, which involved training sessions with plants in the fields and which thus ensured an empirical approach to remedies. Their opinions about the effectiveness of certain medicines derive from sensory experience rather than from the dogma of 'traditional beliefs' or from the latter's counterpart, the science of school curricula, which educated town-people must rely on. The rhythms of life and work among urban dwellers are oriented around school, factory, sales, street or company so most of them lack the farmers' daily experience of dealing with the natural fertility of the land, crops and forest plants. Church sermons about the magic foolishly embraced by so-called 'backward' villagers reinforce the idea of traditional medicine belonging to an illicit realm, separate from daily life. In this paper, parallelism or dualism (see Table 2, later) denotes such a closed relation to other medical epistemologies and such belief-oriented transmission of a medical epistemology. In town, one finds doctrines such as Christianity dominating public discourse, with members proving their religious conversion in a sort of dualism that leaves them fascinated with 'the occult' while fearing it. In the absence of initiation rituals and daily medicinal routines, townspeople have less chance of developing a cosmology based on practical experiences that could inform the advantages versus disadvantages of traditional and biomedical therapies for certain illnesses.

That is how Mshana et al.'s surprising result can be explained. In the classic terms of development anthropology (Hobart 1993), the newly educated in town are structurally in a position of ignorance, having to rely on laboratories and accredited experts for commonly available natural resources such as agricultural seeds or, in this case, plant medicine. So, rather than practising opposite kinds of medicine in a dual world, the rural and urban respondents score differently on a continuum measuring the degree to which people are culturally enabled to develop their own epistemology of healing and adapt it to personal experience.

The empirical in medical epistemologies: mental health care files

The empirical dimension of Sukuma rural epistemologies of healing becomes most evident in their ongoing reliance on healers for those afflictions that Western biomedicine is least able to treat, notably 'mental' illness. The affinity between mental health and traditional healing is a general trend in Africa, as can be established from a quick literature review.[1] In Tanzania's metropolis, Dar Es Salaam, 48% of the 176 clients in Traditional Health Centres (an urban version of the village healer's compound) suffered from mental illness, while among clients of primary health care centres only half of that proportion did (Ngoma, Prince, and Mann 2003). The first port of call for African patients suffering from mental illness is often the traditional healer (cf. Yao et al. 2008, on Ivory Coast). Across rural Africa a plurality of mental health care options exists, with faith consultations, traditional

healing and hospital services paralleling each other (cf. Adewuya and Makanjuola 2009, on Nigeria). Usually, mental illness is associated with a complex causality that may elude biomedicine and find expression in socio-experiential concepts such as 'spirits' and 'witchcraft' (cf. Igreja et al. 2010, on Mozambique; Shibre et al. 2008, on Ethiopia). This strong association between traditional healing and ailments eluding biomedicine should not be underestimated in the field of medical anthropology, long dominated by the concept of 'medical pluralism' (Slikkerveer 1982; Johannessen and Lázár 2006), because it enables us to attribute the fact of pluralism with the empirical basis of health care decisions. Since the affinity between mental health and healing rituals seems to hold for much of rural sub-Saharan Africa, medical anthropologists might consider rejecting pluralism as the default platform of rural health care decisions and develop new, more appropriate nuances within the empirical dimension.

Additional evidence comes from Uganda, where laypeople seem to make informed health care decisions *within* the list of mental illnesses. In a recent study by Abbo et al. (2009) among 387 patients of traditional healers, there was not only a bias towards treatment for mental illness in general (60.2%) but also towards consultations for symptoms that, according to the psychiatrist, pointed specifically to schizophrenia or other psychotic disorders (the prevalence rate of 29.7% was higher than expected). Since such disorders are particularly hard to treat in hospitals, with antipsychotics having many negative side effects (Bentall 2010), there may be an empirical foundation for clients trying out traditional healers with their wide arsenal of ritual therapies.

As the author's ethnographic research on traditional medicine in Sukuma villages progressed since 1995 to include more mixed methods such as quantitative data in 2010, indications have grown as to how empirically driven the health decision-making can be. In the mental health care files of Misungwi district hospital from 2009 (see Table 1), it appears that rural patients rarely consult for schizophrenia (11 out 147, or 7%) while they do for epilepsy and depression. A different picture emerges among urban patients in the same hospital. With a rate of 31% (15 out of 49), they frequently consult for schizophrenia (versus epilepsy and depression). The rural/urban contrast is statistically highly significant ($p < 0.0001$).[2] Might the contrast not reflect a lesser belief among villagers in hospital remedies for schizophrenia or what is called *mayabu*?

The villagers do go to the hospital for epilepsy (*lusalo*). So, far from avoiding the hospital or blindly trusting the healer, they seem to follow a particular epistemology, which discriminates between the afflictions of *lusalo* and *mayabu*. When asked, many know about anticonvulsants for epilepsy. Why then, in the case of schizophrenia, would they not go to the hospital for the antipsychotics? In-depth interviews among

Table 1. Three types of mental health diagnoses in Misungwi hospital (2009).

	Villages	Town	Total
Epilepsy	88	20	108
Schizophrenia	11	15	26
Depression	48	14	62

villagers confirm that, following their experiences with the successes and failures of both healers and hospitals, traditional healing is rumoured to be more effective in treating mental illness – especially *mayabu*, allegedly caused by witchcraft and manifesting itself in psychotic symptoms such as uncontrolled shouting, catatonia and aggressive behaviour. The association is strongest among Sukuma peasant intellectuals who have accomplished the *ihane* medicinal initiation and were registered in the hospital files with a *pagani* or pagan affiliation, also known as 'traditional religious affiliation' (a residual label reserved for patients who not only believe in ancestral spirits and magical protection but also would not associate with Islam, Catholic, Protestant or other denominations). Only one out of 20 *pagani* went to the hospital for what the records label 'schizophrenia'.

Radical empiricism in medicine: *shingila*

Mayabu is invariably claimed to have increased over the years with the introduction of mining and connection to the city after infrastructural works. *Nonga* medicine is said to 'restore the wits' (*kubeja masala*) of *mayabu* patients. Patients with the same symptoms live together at the healer's compound and twice daily receive two sorts of medicine, one of which is meant to counter the witchcraft. The other, *nonga* or 'the shell', is administered from a snail's shell into the patient's nose. The taste is so astringent that some vomit. It contains, among others, pungent pepper residues, which have fermented out in the sun in a soda-bottle hanging on the ancestral altars. Another ingredient is a plant called *fifi* (Artemisia afra Jacq.), commonly used against coughing, possibly in this case to reduce throat inflammation.

The main ingredient of *nonga* is the root of a caper plant (*busisi*), Capparis fascicularis (DC. *var* elaeagnoides). According to ethnopharmacological studies the plant has a significant immuno-stimulant effect of calming the brain's dopamine system, which may reduce psychotic symptoms (Rivera et al. 2003). Moreover, in a process known to botanists as the 'mustard oil bomb', caper plants contain enzymes that, when damaged by a herbivore, break down their glucosinolates into thiocyanates and isothiocyanates, among others. The first component has the potential, after contact with water, to remove cyanide from the body; the second component has been shown to inhibit the development of cancer and tumours (Grubb and Abel 2006).[3]

But the story does not end here. For Sukuma, healers and patients who completed their *ihane* initiation this is actually where the story begins, because for them the empirical (i.e., claims based on experience rather than on logic or belief) implies that medicine should contain, besides plants, an additive called *shingila*, literally 'entrance', which signals the medicine's purpose. In *nonga*, one *shingila* is a piece of a paled broom (*ikumbo lyape*), which expresses the objective of cleaning the body polluted with witchcraft. Another *shingila* is sheep urine, which may be associated with docile behaviour, not irrelevant for *mayabu*. The *ihane* initiation, which all Sukuma men are invited to undertake and which has a female equivalent (although both are disappearing under the pressures from churches and government), is basically a training into *shingila*: namely, the preparation of magical ingredients that give access ('entrance') to recovery by capturing the relation between illness, purpose and the larger world.

Defending a phenomenological approach to bring out this 'enskilment' in medicinal use as opposed to a dualist Cartesian epistemology, Hsu (2010: 28) posits: 'The idea that the self is intrinsic to and inseparable from perception, which phenomenology emphasizes, goes diametrically against the empiricist paradigm of perception.' Indeed, sensory evocative *shingila* are not empirical in the atomistic sense of Humean empiricism, which deals with things such as a disease, a body or a family, but in the *radically* empiricist sense, which considers the relations between these. Although these relations are invisible, people experience them as integrally part of their self.

For a radical empiricist such as William James (1975, 6–7), 'the relations between things, conjunctive as well as disjunctive, are just as much matters of direct particular experience, neither more so nor less so, than the things themselves. [. . .] the parts of experience hold together from next to next by relations that are themselves part of experience.' James hereby objects to 'the rooted rationalist belief that experience as immediately given is all disjunction and no conjunction' (James 1975, 6–7), which presupposes a knower separate from the things, using reason to acquire a truth that transcends temporal experience. For radical empiricists such (individual) reason comes after the event (or is a new event) and rather renders the original experience impure. The sense data obtained through our various modes of perception do not correspond to entities but are real through the relations experienced between the things. It is in the latter (experience) rather than the former (entities) that 'spirits' play an important role in traditional healing.

However, a phenomenology privileging subjectivity seems to have at least one blind spot: how can our observations of relations, of a self inseparable from its object, be put into words other than into those provided by our collective heritage of language? The *ihane* initiation by peasant intellectuals can be said to acknowledge that heritage by teaching the metaphorical language of *shingila*. For large multigenerational families who continuously deal with cases of affliction at home, the main point of reference for diagnosis and remedy is not the individual patient but the collective seeking to live with the fact of illness. Initiatory and other collective traditions possess a knowledge that no individual does. They evolve with people's changed experience of the meaningful relations between things, as illustrated next.

Medicinal intellectuals discussing diagnosis

Monitoring one's symptoms in relation to the effectiveness of a certain treatment, with the option of seeking help elsewhere, is central to Sukuma healing. Both clients and healers are used to a certain degree of failure, to times when the ancestor's wrath was too deep or the witch's schemes too clever to counteract. Much of the interaction between patients in the healer's compound concerns the proper diagnosis of their illness. That this remains an open question, a topic of ongoing conversation, should not be surprising since it is the healers themselves who from the start clarify to incoming patients that they rely on ancestral guides (*masamva*) and mediumship (*bumanga*) for diagnosis. They are bound by what the spirits inspire. Thus, healing is an open search, with not only healers and diviners but also a wide array of community members participating.

One morning in November when the air had been hot and humid as the rains were about to fall, an eight-month-old girl accompanied by her mother was admitted

to the healer's compound where the author worked. The baby died around noon the same day. One assistant-healer expressed his regret to us that his sister, who for several years had been in charge of divinations (he and other siblings said they themselves could not since they never were possessed by the spirits like she was), had not managed to mount the spirit that morning. Otherwise she might have come up with the proper remedy. As the group conversed quietly, to not disturb the deceased's family members mourning nearby, a neighbour joined in to speculate on the cause of death. Did the mother not lose her previous child as well? He concluded that the mother suffered from either *loya*, 'little hair', or *masinzo*, 'scissors'. The two conditions are alike in their affecting of infants and in their endurance until the mother removes the cause. (Neither children's disease implicates witches). *Loya* refers to a little black hair on the mother's back that, soon after contact with the infant carried on the back, will lethally inflict the baby. The problem returns until removal of the fatal hair. The cause of *masinzo* is located in the mother's vagina, where two scissor-like bits of tissue would grow towards each other until about eight to ten months after birth when the 'scissors' close off the womb and in this way end the infant's life. (For Sukuma, a child's fate is intimately connected with that of the mother until several years after birth, so these early deaths are considered miscarriages.) Because the child died after eight months, *masinzo* seemed to our neighbour the most probable diagnosis.

The wife of the first speaker, the healer's son, disagreed. She reminded everyone that the woman's two previous infants died aged 1.5 and 2 years, which is too late for either 'little hair' or 'scissors'. It must be a *njimu*, she continued, a bad ancestor, who obstructs her fertility before or after pregnancy. *Njimu* refers to an ancestor who controls female fertility. The ancestor is located on a woman's matrilateral side, *ku migongo*, literally on the side 'of the backs'. The back has a strong maternal connotation. Failing to observe traditional rules at marriage such as dedicating a sheep to one's new wife may arouse a *njimu* curse. Her husband agreed and added that performing a collective ritual in honour of that *njimu* ancestor (who would have to be identified through oracles) could prevent this lady from losing any further children. That, he said, will be the probable outcome of discussions following the burial.

Some months later he talked differently about the ritual when his three-year-old girl Nkwimba got ill with high fever and severe convulsions (*nzoka ya ntwe*, 'snake of the head', better known in Swahili as *degedege*). Two mediumistic divinations, one by a diviner in the village of Mapilinga and one by his sister, revealed the demands of an ancestor who 'died in the wild', meaning outside the compound, which is considered the most ominous death. These oracles were independently confirmed by a chicken divination performed by the village elder Ngwana Chonja. The chicken oracle showed a double white outgrowth on the bird's back known as 'the two gourds' (*shisabo ibili*) which points to the role of an ancestor (who favours gourds over tin pots for food) and more exactly evokes his demand of ritually sacrificing two sheep in his honour. To the author's surprise, the healer's son chose not to follow the diviner's advice. 'Nowadays we, Sukuma, avoid sacrificial rituals because these do not prevent evil', he explained to the author in the company of his siblings. In funerals there is nothing wrong about a placating ceremony 'doing what will be refused anyway' (*kwita agalemagwa*). But in illness one has to be careful with interventions: 'The ancestors can get satiated. After the sacrifice they can lift their

protection altogether and the child dies.' This tendency to immediate gratification instead of long-term exchanges of gifts was the general trend among Sukuma today, he further explained: in the past, the brideprice for marriage was paid in instalments, whereas nowadays the bride's family demands from the groom to 'complete once and for all' (*kumala gete*), that is, to hand over all the cattle during the wedding. He intuited a collective change in which the Sukuma and their ancestors participate.

Traditional cosmological concepts such as *loya*, *masinzo* and *njimu* structure people's health care decisions, whereby personal medical histories are verified. The 'truth' (*ng'hana*) is discussed in relation to past observations and new evidence. The relationship between ancestors, satisfaction and sacrifice makes therapeutic choices meaningful for the participants. And this relationship can change, as in the new aversion to sacrifice. To express his radically empiricist intuition, the healer's son referred to the collective. He voiced his health-care decisions in terms of 'we Sukuma', echoing the many medical conversations he regularly has with other peasant intellectuals in the family, the neighbourhood and beyond. An etiology attributing a woman's infertility to ancestral demands is radically empiricist in expressing the intuited relationship between affliction, remedy and communal peace. At a collective level such etiology is not less 'empirical' than a biomedical explanation. The latter could hardly prompt the community into a better response to infertility.

So, reading the signs of a current trend, the healer's son dropped the idea of ritual sacrifice. His wife continued what she had been doing all along to improve her fertility and in this way keep her child healthy, namely to daily smear her body downwards from top to toes with a medicinal preparation named *bugota wa njimu* (*njimu* medicine). Therapy thus consisted of engaging with medicinal plants, tapping into their intrinsic force without having to communicate with the ancestral spirits and depend on their accord. From this increased autonomy thanks to medicinal plants, it is a small step to preferring pharmaceutics. There can be no doubt that despite the clinical architecture, personnel, uniform and separate location by which hospitals stand out (thus materializing and institutionalizing a certain dualism with other medical services on the local pluralist market), biomedicine has much to offer that Sukuma patients desire today and that suits those hesitant about complex ancestral rites. Biomedicine attracts not so much for representing the West's expertise as for fitting in with the local, now transformed epistemology of healing (see Geissler and Prince 2010, 171). That epistemology is not fixed. Like Luo mothers in Kenya (Geissler and Prince 2010, 169), Sukuma respondents conceive of their existential condition as a continuous search. Yet, rooted in vibrant medicinal traditions and driven by empirical assessments of past interventions, as illustrated by the conversation above, it is a confident rather than Sisyphean search.

Synthesis: four types of medical cosmology

A radically empiricist epistemology of healing differs from the atomistic empiricism privileged by positivism, in that it acknowledges the 'relations' between things as part of human experience. Because these relations are less easily articulated, this epistemology of healing cannot be dogmatic, or dismissive of other medical epistemologies. The health-care decisions of Sukuma peasant intellectuals are inconclusive and inclusive, not because the empirical burden that they place on

themselves is low, but rather to the contrary: for them the temporary calming effect of *nonga* (possibly due to the *busisi* plant's dopamine balancing) issues from a *shingila* that restores peace (*mhola*) at the more durable, socio-cosmological level. So, while staying in the hospital, patients will continue using such magical ingredients, clandestinely if necessary (cf. Langwick 2008).

This open relation to other epistemologies contrasts with the empiricism of the medical profession echoed by Angell and Kassirer (1998, 841): 'There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. Once a treatment has been tested rigorously, it no longer matters whether it was considered alternative at the outset.' While thus cogently rejecting the dualism opposing biomedicine and alternative medicine, the authors opt for a monist take on medicine. A medicine will remain labelled as alternative (or traditional) when its effectiveness has not been proven in a lab, which places alternative medicine always – structurally – on the losing side: if it works it will eventually be called conventional. This is monist for denying the blind spot of scientific methodology. Not everything affecting health fits in a lab.

Like any social domain, biomedicine is epistemologically heterogeneous. Yet, as Stengers (1995) has remarked about the obsession of the medical profession with charlatans, a universalism subtends the medical sciences. The integration of alternatives has been scientifically fruitful but also attests to a closed relation with other epistemologies. Another type is the medical dualism of Christians, proving their conversion by denouncing traditional medicine (or some denominations forbidding biomedicine). The subjugation of other epistemologies by medical dualists (and monists) contrasts with the de facto medical pluralism of most patients in the world, many of whom appreciate the segregation of hospital and healer's compound, which actually permits pluralism. Medical pluralism is what most of us engage in who consume without obeying dogma or developing new remedies. We transmit the epistemology through cultural habit rather than experiential validation.

Sukuma peasant intellectuals belong to none of the above three types because, ever since their medicinal initiation, they have learned to assess health care services and contribute to the design of additives and healing rituals. In comparison to monism, with its universalist claim and separation of the experts from lay people, they display a constructivist (versus substantivist or hierarchical) approach to other epistemologies.[4] The Western counterpart of this fourth type may be psychotherapists willing to learn from healers (cf. Devisch 1993: Maiello 2008).

Table 2 schematizes four types of medical epistemology (or cosmology, defined broadly as an ordering of the world). In the left column of the table, a closed relation

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

	Relation	
Transmission	Closed	Open
Habitual	Dualism	Pluralism
Empirical	Monism	Radical empiricism

between medical epistemologies imposes hierarchy between the epistemologies (monism) as in positivism, or imposes segregation (dualism) as in certain Christian denominations. The spontaneous, de facto pluralism (above right) can be found in culturally diverse communities across the world, and also among clients with a post-modern epistemology. This pluralism will turn into radical empiricism, a fourth type, when the open approach to cosmologies is accompanied by decisions that are empirically based and mediated by the collective.

The author believes this fourfold and two-dimensional division of health care decisions to be more useful than current non-differentiations that implicitly condone dichotomies opposing biomedicine to traditional medicine, urban to rural users, Westerners to Africans, or universalists to pluralists.

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Conflict of interest: none.

Notes

1. When searching on the Pubmed database with the terms 'Traditional medicine OR traditional healing OR traditional healers AND Africa AND mental' 205 papers in total were obtained. Forty-eight dated from 2000 until 2010. After exclusion on the basis of irrelevance (e.g., other afflictions such as stroke; 'mental' as a kind of effect; pharmacological study; other region than Africa), 31 papers were left, the main outcomes of which are presented briefly here.
2. The Chi-square is 17.4 with two degrees of freedom. The possibly higher prevalence of schizophrenia in urban areas cannot fully account for the urban-rural contrast (cf. Mortensen et al. 1999, measuring a disparity of schizophrenia risk with factor 2,4 between Denmark's largest city and the country's most rural area).
3. The author is indebted to Suzy Huysmans of the KU Leuven Laboratory of Plant Systematics for references and plant identification in 2006.
4. This does not refer to Horton's (1967) open predicament of 'Western modern science' seeking verification versus the closed predicament of 'African traditional thought' fearing falsification (an opposition of predicaments which the author's stance would then seem to invert; see also Trawick 1987). What mattered in this paper is the practical relation – observed in the practice of health seekers – to other epistemologies, and not the position taken by a belief or a theory in relation to data conflicting with it.

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