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"When there are no problems, we are healthy, no bad luck, nothing": Towards an Emancipatory Understanding of Health and Medicine

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INTRODUCTION

When we speak of rival knowledges today, most analyses begin by presenting modern knowledge systems—such as biomedicine—as globalized forms of knowledge (Chavunduka, 1994; Wynne, 1994; Mappa, 1998). In several studies produced in Africa, the act of situating the "other's" knowledge becomes the key moment in the production of a relationship of inequality; from this standpoint, pre-modern forms of healthcare are characterized, *en bloc*, as traditional therapies, frequently of only local relevance (Ngubane, 1981; Hewson, 1998). The definition of traditional midwifery and of healing and herbal medicine as the main components of "traditional medicine" (WHO, 1996) manifests an extreme simplification of the concept of health, which fails to take note of the historical, social, economic, political, and cultural specificities underlying the development of knowledge about health (Meneses, 2000).

In Mozambique, in most of the work on "traditional medicine," the dominant discourse confers on modern science a hegemonic status, which is defined and protected by the state as "official knowledge."[1] In contrast, local, native forms of knowledge are given a secondary position (Marrato, 1995; Tsenane, 1999; Instituto Nacional de Estatística, 1999). The search for a definition of "traditional medicine" that goes beyond the diversity and heterogeneous character of its therapeutic practices and knowledges is inscribed in the social order resulting from the process of colonization of knowledge itself. What transforms these practices into objects is simply the state's refusal to recognize them (Santos, 1995).

The alternative hypothesis that I would like to discuss in this study is based on the argument that the forms and practices of so-called "traditional" knowledge constitute in fact legitimate knowledge, a status that is conferred on them by the considerable number of patients that seek traditional doctors.

This fact may help explain the enormous vitality and persistence of such practices, both in the colonial period and the present day, notwithstanding the repeated attempts at "epistemicide"[2] to which these forms of knowledge about health have been subjected. Yet many other aspects have to be explored: for example, what is alternative medicine? Alternative in relation to what and whom? What should be considered legitimate knowledge? Legitimate in whose eyes? For knowledge to transform itself into solidarity, which guarantees the liberty and equality of each culture, it is necessary to give that "other" culture the status of subject.[3]

Questioning the dichotomous relationship between local and global forms of knowledge, seen from the perspective of the evolution of "traditional" medicine, is the main analytical focus of the present research. The data and ideas presented here are the product of a research project that I have been carrying out for over eighteen months in the city of Maputo, especially in the neighborhood of Polana Caniço (in the city's suburban area). This is an extraordinarily complex region, of considerable cultural wealth, where there are various health systems that frequently intersect and interpenetrate. To analyze this plurality of medical systems (MacCormack, 1986) is not an easy task, since the interaction of elements of different medicines and the differing perceptions of individuals and social groups about health, well-being, and disease create an immensely complex fabric that manifests itself in forms of "inter-medicine."[4]

In a world of permanent production of cultural differentiation, this process acts as a catalyst of spaces crossed by political and economic relations deeply rooted in inequality. Therefore, in this study, the initial discussion will be focused on the questioning of the reasons that have led to the construction of this difference. Who is the "other," the one that produces and preserves other forms of knowledge?

In order to evaluate existing perceptions about the distinct medical systems in place, several interviews were carried out, both with practitioners of traditional medicine and their patients as well as with participants in the elaboration of health policies in Mozambique (governmental organizations and NGOs). The in-depth interviews involved about thirty people, whose ages varied between 22 and 60 years. Most were interviewed separately. Most of the data presented and discussed comes from interviews with "traditional doctors" from the new board of directors of AMETRAMO,[5] who shared with me, almost on a daily basis, their ideas about their practice and knowledge, their problems and doubts.

To write a text using as a narrative basis "other" perceptions of knowledge was not an easy task.[6] While adapting myself to another, quite complex and dynamic, world, I came to realize that a reflection on how to emancipate this knowledge could only be achieved by producing a *mestizo* text. This explains my decision to write a text that shifts from a situated narrative to a more detailed

analysis of the topic, avoiding the elaboration of a stereotyped image of the "other"; this was made possible by presenting the subjects in their own words and perspectives, each with his/her own individual identity. The choice of personal narratives allows me to present the process of construction of the particular "self" of each subject while also evaluating the narrators' biases. In this text, the "I's" became an active component of the discourse, a part of the analysis of the phenomenon, and not the phenomenon itself, raising many questions still to be explored in the future. This has required a detour through the interpretative field of the very concept of health, a reconsideration of the place and role of existing medicines in Mozambique, in which the voices of several of the actors involved in this question are heard.

MEDICINE AND MEDICINES

In the midst of several conversations that I had with a traditional doctor, she would say to me: "there are our diseases, traditional [diseases], but there in the college [Faculty of Medicine] they don't know what these are. But when there are problems we don't understand, we send them to the hospital."[7] These words underline the statement made by several authors about how illnesses or maladies are explained: etiologies are a direct expression of the norms and representations that sustain social structures (transgressions of prohibitions, manifestations of ancestral spirits, aggression by witches, etc. [Dozon, 1987; Hess, 1994]).

In a country like Mozambique, with an extremely complex socio-cultural fabric, there is an unquestionable mixture of medical subcultures, each with its own characteristics and structures, although, through ignorance, biomedicine describes them as a homogeneous entity, resulting in the general reference to a single traditional medicine (Nordstrom, 1991; Jurg, 1992; FRELIMO, 1999). This stereotype, the product of colonial situations, is still very prevalent today.

As I shall discuss in the body of this chapter, it has been possible for some time to detect the development of medical hybridization in Mozambique, a hybridization that accepts the modern model of medicine and even creates space for its practice. Seen from this angle, the vitality of traditional medicines reflects the difficulties of a biomedicine that seems to be unable to achieve its objectives. The hybridization of therapeutic knowledges constitutes a complex diversity of transformed appropriations that are not by any means fixed in space and time, as so often is imputed to "traditional values."[8]

As a starting point, the analysis of this plurality of medical systems is made through the cautious use of the variables official/non-official, traditional/modern. Caution is necessary precisely because of the situation of intermedicine, of the constant mixing and intersecting of decisions that give rise to a multiplicity of hybrid situations.

The official/non-official dichotomy is defined by the state, which establishes by law—among the wide variety of therapeutic forms—a more or less explicit distinction between what is legal and what is illicit, if not illegal. Everything recognized as official medicine is the object of support by the state. Medicine not recognized as official is tolerated, but most frequently ignored, due to its low permeability to the impositions and control of biomedicine.

The ongoing formalization of traditional medicine is the cause of its own fragility, and this normative process is a reflex of the character of the state in Mozambique. From the perspective of modern medicine, traditional medicine encompasses several knowledges, such as biology and chemistry (i.e., plants and their extracts used as remedies), biomedicine (the treatment and curing of the body), justice (the resolution of problems and conflicts that express themselves in bodily illnesses), and religion (explanations for beliefs described in terms of a magico-religious set of concepts). This reduction of the complexity of knowledge to a list of scientific fields, through the compartmentalization and normalization of knowledge, is the most visible expression of the state's formalization.

Indeed, in the "traditional" sphere, the institutions that take on the healing of illness are simultaneously political, therapeutic, juridical, and religious; they cover an extensive field of competencies and functions that place the efficacy of treatment within a more enveloping efficacy, bringing into play institutions of authority, normative and symbolic structures, and relations of force, knowledge, and power (Fisiy and Geschiere, 1990, 1996; Geschiere, 1995, Fisiy and Goheen, 1998; Comaroff and Comaroff, 1999).

This requires that we make a careful evaluation of the traditional/modern variable when we look at the origin and development of medicines in Mozambique. In the modern, Eurocentric view, the qualifier "traditional" applied to medical practices is used to refer to collective knowledge that has "always" existed, thus reinforcing the object status of those who produce it. In Mozambique, the traditionalization of local knowledges emerges in parallel with and in opposition to the biomedical paradigm that began to be introduced in the late nineteenth century. Depending on the social concerns of each pillar of this dichotomy, the traditional can be seen as an invention of the modern, or the modern a creation of the traditional. As the traditional doctor Carolina Tamele told me, "traditional medicine is ours, we cannot write, it is not like over there at the university. But we study a lot to learn how to heal; we know things they do not teach in school."[9]

Modern medicine appears only as another therapeutic practice in this region, and it does not constitute, even today, a real competitor to other medicines,[10] which have maintained their vitality. The common denominator is to be found, paradoxically, in the fact that these "traditional" medicines have the advantage of not constituting an autonomous domain,

enclosed by a body of rules, knowledge, practices, and specialists. In fact, so-called "traditional" medicines are embedded in many other sectors of social life—in this sense, they require that we redefine the concept of "illness," of "malady," which goes beyond the notion of misfortune or unhappiness, and which includes cognitive, symbolic, and institutional aspects of society.

As mentioned above, the fundamental question to be posed is how the dynamics of hybridization of these medicines developed. This universe testifies to the coexistence in the social sphere of the institutions that treat illness and malady in general, at the same time that they treat society itself—whether such treatment is to ensure the reproduction and maintenance of the existing order (norms, representations) or its perturbation (tensions, conflicts, collective misfortunes). In this process lies the heart of the internal resilience of traditional medicines in Mozambique.

THE INVENTION OF TRADITIONAL MEDICINE

Illness, as a sign of maladjustment, of individual and social imbalance, is, like other signs, the object of ambiguous and fluid representations, constructed as practices of knowledge and the exercise of power (Appadurai, 1999; Santos, 1995, 2000). In a world where the hegemonic imposition of scientific knowledge is widely present but in contest with other forms of knowledge, one of the main battles concerns what needs to be known (or ignored), how to represent this knowledge, and for whom.

In Mozambique, the search for a definition of "traditional medicine," beyond the evident diversity and heterogeneity of therapeutic practices, has to be inscribed in the social order resulting from the process of the colonization of knowledge itself—what turns these practices into an object is simply their non-recognition by the state[11] and its institutions.[12] This process implies the creation of the "other" as non-knowledge, included in the natural world and excluded from the civilized world (see, for example, Liengme, 1844–1894; Maugham, 1906; Pina, 1940; Silva Tavares, 1948; Santos Reis, 1952). Therapeutic knowledges and practices are then fragmented according to the classification systems of modern science. This compartmentalization of knowledge allowed the colonial system to appropriate the pharmacological principles of various products used by local therapists, as is shown in various records of Portuguese scientists working in Mozambique: "The remedies employed by indigenous doctors are numerous; they use them in many illnesses and at times with notable success. There is much to study in local plants, some of which may be of use" (Santos Junior and Barros, 1952: 615). At the same time, the process of situating this knowledge, and then restricting it to a symbolic content, invests the communities that possess it with an exotic aura, making them relevant

for anthropological study, as well as for ethnic tourism (Meneses, 2000). In identifying local knowledge as "sacred," the focus of action is diverted from its creators, while at the same time the barriers between Self and Other are continuously reinforced, thus sustaining knowledge as colonization.

The excerpts presented below constitute examples of the subterranean continuity of a discourse in which the opposition between medicine and magic is reinforced through the division between biomedicine and traditional medicine. Both in the past and in the present, "traditional medicine" is associated with localized, native, or indigenous knowledge (Batalha, 1985; Green, 1996; Hewson, 1998; Green *et al.*, 1999).

> The witchdoctor does not offer anything out of the ordinary. He is a black like the others [. . .], he is only smart enough to win their respect, inducing in them a mystified respect for his clinical procedures, divination abilities, and resources to resolve various difficulties in life. [. . .] But in general he is no more than a swindler (Cruz, 1910: 140).

In this excerpt, it is important to observe the hostility with which medical practices are evaluated, and also how the traditional doctor and the witch-doctor are conflated.

> After the diagnosis, in which the physical symptoms are always downplayed, the sick are advised [by the "black doctors"] according to whether their conditions were caused by spirits of gods, witches, pollution by the dead. [. . .] However, the "black doctor" is not generally a charlatan; he works conscientiously and is confident in his knowledge (Schwalbach and Schwalbach, 1970).

Another characteristic aspect of modern medicine is its low degree of openness towards other possible forms of diagnosis, which, because they are different, are not recognized as equally important as auxiliary means of detecting illnesses.

> There are healers who actually perform cures by using certain medicines obtained from roots, plants, etc., but spiritual healing is, from all viewpoints, negative and obscurantist *par excellence* [. . .] (Castanheira, 1979: 12).

> [Traditional medicine is] a collection of unorganized empirical knowledge, distorted in its contents by the process of oral transmission, and often surrounded by obscurantist practices, such as rites, etc. [It is the function of the GEMT[13]] to cleanse such existing knowledge of all obscurantist ideas with which it is usually impregnated, and thus promote its value as scientific knowledge to the benefit of the people as a whole (Serviço de Nutrição, 1981: 3–5).

These last two extracts, both produced in Mozambique after independence, illustrate the attempt to impose modern knowledge through the annihilation of practices that did not fit the project of development proposed by the FRELIMO party (in power since independence) and supported by the state.

Finally, the next quotation, while trying to make a clearer differentiation between traditional and modern medicine, reinforces the above proposal of FRELIMO's government (regarding the duality of practices), implicitly supporting the subordination of tradition to modernity:

> In many traditional cultures [of southern Africa], illness is thought to be caused by psychological conflicts or disturbed social relationships that create a disequilibrium expressed in the form of physical or mental problems. In contrast, medical science rests on the axiom of Cartesian dualism, or the separation of mind and body [. . .]; the primary concern is healing the body and eliminating physical suffering. (Hewson, 1998: 1029)

By mediating between the performance of an act and the intention of those who select the content of representations, it is possible to produce phenomena that are a distortion of reality, and which justify the preservation of the binary and geographically specific opposition we/others (Goody, 1979: 35; Barth, 1995; Santos, 2000).

The hegemony of modern science results in the local confinement of knowledge, which can be both the cause of discrimination as well as the basis of resistance to this form of globalization. But how do traditional doctors see themselves? Localism appears as a form of security and affirmation of what is specific to themselves, of a knowledge that belongs to them and that thus enables them to acquire space for maneuvering, spaces of empowerment.

For traditional doctors, their "medicine" is what happens "here, in our space."[14] The patients themselves establish a very clear distinction between the limits and application of biomedicine and those of traditional medicine. The distinction is made according to the context of production/reproduction of knowledge about good and evil.

TRADITIONAL DOCTORS AND TRADITIONAL MEDICINE: THE CONCEPT OF HEALTH[15]

"To have good health is to have a good life . . ."

For the majority of the population of Maputo city, and even the whole of southern Mozambique, the concept of health is very broad, referring implicitly to the existence of a social balance, a concept not unique to Mozambique or Africa, since it is present in various cultures with distinct medical systems.

"To have a good life" are words that best summarize what is meant by being in good health. A good life translates into "having a well-built house, enough food, money for clothing, for soap, for the children to go to school, for the hospital;"[16] "we feel good when there are no problems, when we have food, and when the family is fine."[17] The expression of these feelings suggests that in order to be in good health it is necessary to achieve an internal balance, to be at peace with one's family (including one's ancestors), with neighbors, with one's own body (including hygiene); to be properly fed (which means having employment to ensure income) and protected from ills, whether natural or "visited." When someone produces a lot, has a good harvest, finds a good job or has a good house, a member of the family or a friend may envy such wealth and resort to a traditional therapist to cast a spell against that person. "People today suffer much from bad luck, and even die as a result of jinxes, without deserving such a fate [. . .]."[18]

These conceptions about the role of traditional doctors require a deeper analysis, as well as a re-evaluation of both the ethical and emic principles underlying the emergence of concepts concerning traditional medicine.

Medicine and witchcraft

A discussion of the ethical boundaries of a medical system that extends far beyond the established limits of biomedicine implies broadening the analysis to the field of so-called witchcraft.

As mentioned above, the process of negation of knowledge of traditional medicine involved the identification of the image of the healer with that of the witchdoctor.[19] But these are in fact entirely different, as both patients and practitioners of traditional medicine attest:

> There is a difference between a healer and a witchdoctor. A healer cures, and a witchdoctor kills. A witchdoctor knows potions that kill. But we healers cure, because that is our duty [. . .]; otherwise the spirits may punish us.[20]

To overcome misfortune or bad luck it is necessary to get the help of the traditional healer so as to re-establish individual balance. But a traditional healer can also be used with malicious intent:

> [. . .] spells result from ambition and hatred between people [. . .]. There are poisonous plants and animals that, when used malevolently, can cause evil [. . .]. There are harmful roots [. . .]. There are directors who contact us to help them resolve problems in government, or even when they need to have more power for governing. There are plants that help resolve social problems and complications at work.[21]

The constant demand for traditional medicine is more visible today because there are many more individuals on whom the fortunes of modern or, indeed, traditional society have not shone, and who are searching for success—through promotion, wealth, and business opportunities, for example.

The very classification of illnesses being treated by traditional doctors working in Maputo is very different from that used in biomedicine. Side by side with epilepsy, scabies, tuberculosis, and "eye pain," there are also other pathologies such as "marital problems," "witchcraft," "bad luck," and "evil spirits." In the "traditional" sector of society, if things do not go well, when production fails, when there is "misfortune," the traditional doctor is consulted to find and explain the source of the problem, and also to give medicines either to eliminate it or to restore relations with the ancestors.

The primary available sources for the analysis of witchcraft consist of accusations and rumors,[22] which raise numerous problems in the evaluation of its persistence and efficacy.

> Since crimes of this nature are not resolved by the authorities or the courts because of lack of material evidence, [. . .] people die, fall sick, and remain paralyzed as a result of these Dantesque barbarities perpetrated by witch-doctors who rule and proliferate in our villages and towns. The law ignores them, and sometimes even goes so far as to defend them. What is the difference between an assassination through witchcraft and that through stabbing or shooting? Is it not the same crime? Just because the former is done furtively and through the spirits? Or is there fear on the part of the authorities when they distance themselves from the serious problem of tradition lest they find out that after all witchdoctors operate even within the legal system? (Phaindanne, 2000)

First, we should notice the pertinence of the opposition between scientific knowledge and local representations in the discourse about the "other." Although today this idea is prevalent in many studies, what is important to see is who benefits from these situations and how witchcraft is related to the reproduction or the rupture of the social order. The persistence of the phenomenon of accusations of witchcraft—while implying a marked ambiguity insofar as it is related to some form of power—shows that it is essential to the functioning of society, providing a supplementary force that may even serve constructive ends. Thus, witchcraft should be seen as constituting a possibility for resisting change and continuously emerging inequalities; it may also stimulate attempts to appropriate new resources.

> There are people who become rich at the expense of their family or work colleagues. To become bosses, to succeed better in life, they go to the healer.

> The [traditional] doctor throws the bones,[23] invokes the ancestors' help for increasing the power of the ambitious person over his "enemy." No one can then do anything, unless it is to find a more powerful doctor than the one who made the medicine for him to prosper and have more power at work, to be a greater boss [. . .]. I came here just because I want to keep straight with my family, I came to be "vaccinated," if not all will go awry at work, there is so much envy [. . .].[24]

The tenacity with which witchcraft prevails in Mozambican society means that conceptions of power and its exercise have specific implications, since these situations are symmetrical in terms of feelings of power (protection—traditional doctor) and impotence (envy—witchcraft). Traditional medicine offers means to build up power but at the same time reflects feelings of impotence, since it appears to serve to conceal the sources of power. In societies in which the role of family networks is very strong, witchcraft and the appeal to the traditional doctor for social promotion show how closely connected these two phenomena are, a subject analyzed in more detail below.

The discourse on witchcraft is not exclusive to Mozambique (Geschiere, 1995; Englund, 1996; Mappa, 1998; Comaroff and Comaroff, 1999) or even to Africa (Taussing, 1987; Escobar and Pardo, 2000). However, in the region where this study took place, witchcraft operates as a privileged mirror that permits greater manipulation of the "traditional" in the struggle for the construction of "another modernity."

Discourses concerning witchcraft do not express a resistance to modern development; rather, they are reflexes of a constant struggle for a better life. Because traditional medicine is an open system, formally delimited only at the level of the statutes of one association,[25] there are innumerable possibilities for explaining the problems that people experience in life. This enables an anthropophagic interaction of different elements that are part of the project of the creation of "another modernity" (Ong, 1996; Santos and Trindade, 2000). In this sense, witchcraft accusations, far from reinforcing a radically different otherness due to the strange exoticism of witchcraft, constitute a discourse of struggle concerning problems that affect the family, the community, and society.

From the brief collection of opinions presented above, what seems to emerge specifically is the fact that in a context of searching for solutions for misfortune or malady, the concepts of conflict and social imbalance are the central axis around which the whole process of the treatment and cure of the person affected revolves. It is this social space that is occupied by the figure of the traditional doctor.

Who is the traditional doctor?

Although there are various designations for traditional therapists, the most common is "*nyàngà.*"[26] The *nyàngà* is a doctor who heals, who knows the power of medicines and how to heal with the help of ancestral spirits. In a text that seeks to give voice to distinct actors, it is necessary to allow traditional doctors to introduce themselves, to define their specificity as well as areas of contact with modern doctors.

An interesting aspect is the fact that all traditional doctors refer to the initial period in "their calling" by their ancestors' spirits to learn to be healers as a very difficult period, one of pain and suffering:

> I was in South Africa working in the mines and I fell very sick, I could not work [. . .]. Then I came to Mozambique, I consulted a doctor who told me that I had spirits that wanted to come out [. . .]. I took the course and I became a traditional doctor. [. . .] I learned a lot, because it is not just spirits, it is knowing how to heal with plants, to help people.[27]
>
> In order to have the spirits that today help me being a healer, first I became very ill, very, very ill . . . I did not do anything for almost three years, I couldn't work in the fields, I could not even eat. They took me to the hospital [. . .]. Then I was told I had the spirits, and [my family] sent me to become a healer.[28]

The selection of the future traditional doctor occurs through a mechanism of painful rupture (simultaneously physical and spiritual)[29] with his/her family and community, a mechanism that seems to be beyond the control of the would-be healer. During the process of perception of his/her new social role, the candidate suffers from innumerable physical and psychological maladies that have no plausible explanation (and which thus cannot be cured within the biomedical paradigm). This unexplained malady works as a password for admission into a different universe of knowledge, which is the basis of the doctor's power of decision in the solving of problems he/she will have to deal with in his/her therapeutic practice.[30] This ritual rupture happens whenever a problem of some gravity occurs, a problem that requires great seriousness and knowledge: "[. . .] afterwards, even when we are working and the spirits come out, it hurts a lot, I lose the power of my arms and legs, I cannot move or do anything at all. It is really painful when they come out in us."[31] As several traditional doctors mentioned, ancestral spirits[32] momentarily occupy the therapist's body in order to help him/her with the diagnosis and detection of the roots of the problem, as well as with the selection of the necessary medication.

The period of apprenticeship of a "*thwasana*"[33] usually lasts from two to five years, and may be even longer. Under the supervision of his/her ancestors (who have chosen this person to perpetuate their knowledge), the candidate has to select the "*b'ava*"[34] with whom he will learn to become a qualified therapist.

> It is hard to be a healer. We have to learn a lot. We have to learn to know the origin of the problem, know the plants that cure, know the different illnesses and how to cure them, with what plants, animals, and many other things. You have to be very careful not to make mistakes. We learn to recognize and distinguish all of this, and afterwards in meetings we talk with our colleagues.[35]

It is not easy to learn to become a traditional doctor, and the ethical principles involving human beings are shown both in the concern about avoiding errors and in the professional secrecy about the patient's ailments, among other aspects.

Illness is something abnormal installed in the body, which, as it comes to be felt as pain or discomfort, alters the person's normal balance.[36] It is therefore necessary to locate and treat the physical or spiritual source of the problem and re-establish normalcy. The ailment may be derived from not fulfilling social rules (such as "*timhamba*"[37]), from the dead not having been properly buried, contagion from impure objects, and the action of malevolent spirits (the "*valòyi*"[38]).

> Often people come here to consult me because of wrongs they did, and because things are going badly, because there is misfortune in their lives. There are also many men with diseases they get from women; this is a great problem here in Maputo, even AIDS [although she refused to say whether she can treat AIDS]. I use the "tinholo." Sometimes the reply comes quickly, at other times not. Each occasion is different. But it is only like this that I manage to find out properly what the person has got. [. . .] In other cases, "kufemba"[39] is necessary, to see what spirits the patient has. They will say what they want. Past problems that they have not solved. During the war, in Gaza, many people died, even our people were killed. Now you may be passing through, and a spirit comes out and stays inside you, needing to resolve its problem. You become really sick, get thinner and thinner, and no one in the hospital can help. Only the traditional doctor can, s/he has to do the treatment to allow these spirits to come out and give them what they need to be happy.[40]

Thus, the cause of the ailment is defined by identifying the alien object that has got into a person's body through different means (touch, sight, or smell). To alleviate the ailment, it is necessary to use medicines—"*mìrhri*"[41]—that

allow the patient to recover their full state of health. These medicines are used to heal the body, to cure the pain that assails a particular part of the person, and at the same time to restore self-confidence. The "*nyàngà*" cures the body, heals the wounds, and eliminates the suffering of the organism by using the knowledge he/she has of nature, and simultaneously treats the perturbations of the mind and spirit that are caused by socioeconomic imbalances or by traumas at work.

About illnesses

Traditional doctors seem to know best how to deal with so-called "traditional" illnesses—i.e., illnesses with a heavy emotional component—because they deal with the body and the spirits that "invade" the body and cause diverse problems to patients. Thus, the "*nyàngà*" plays a double role—divinatory and curative—based on a broader conception of illness, understood at two levels: as a social phenomenon, resulting in deep changes in everyday life; and as a physical phenomenon, a manifestation of changes in someone's body. The divinatory function seeks to treat the causes of the illness, prescribing several means to solve it. The curative function seeks to eliminate the physical symptoms. These two functions complement each other, and both help cure the patient. For the traditional doctor, healing means removing all the impurities or imbalances from the patient's life, and thus each treatment normally ends with a purification ceremony that aims to prevent similar situations from happening in the future.

In Mozambican society, as in other societies, witchcraft acts as a regulatory element for dissonant social pressures (Meneses, 2000; Santos and Trindade, 2000). Those who have a lot of money or power do so because they have taken it from someone else with the help of somebody. Those who die, those who suffer "misfortunes," do so because they are "sick," have problems with success, or there is someone who dislikes the fact of their being different; it may also be somebody trying to break away from his/her social group.

For example, infertility is sometimes interpreted as having been caused by someone who does not want a woman to stick with her husband, which in the last instance would imply the annulment of the marriage and the weakening of family and community ties. For the resolution of this problem, all possible means are employed, including "non-traditional" medicines:

> [. . .] when a woman does not conceive, we treat her, and after a month we advise her to go to the hospital to have it checked. Then she returns and we carry out a treatment to "secure" the pregnancy, the baby in the mother's womb. All this is important, the hospital in addition to our medicines. Then there are no problems.[42]

Traditional doctors recognize that they are not able to resolve all cases presented to them, and frequently, after several failed attempts to treat a problem, they suggest that the patient consult practitioners of other medicines, including biomedicine (symbolized by the hospital).

Thus, the plurality of medical systems makes it possible to resort simultaneously to different forms of "treatment" that can identify problems with a physical expression. In parallel, there is also a system that punishes and regulates maladies. They are two sides of the same coin, the physical and the social ills, the individual and community conflicts and tensions, in a system still very much in transition (and quite often at the brink of collapse) to a capitalist society of individual accumulation.

The way in which illnesses are perceived and the attempts to cure or prevent them have to be understood and discussed within the context of each of the existing systems of knowledge—that of biomedicine and that of traditional medicine—since the notions of causality (etiology) do not always coincide. Like their patients, traditional doctors do not necessarily distinguish between healing and treating, between objective and subjective symptoms, between measurable and non-measurable clinical data, which are essential questions to the practice of biomedicine. The traditional doctor is interested in resolving the problem and controlling the symptoms, in restoring the physical functions and social relations that have been affected. As M. F. Zimba puts it, "when the head doesn't work the body suffers," thus summarizing the main premise of his work as a traditional doctor. Although other forms of medicine also advocate the principle that the cause of an illness lies in a person's imbalance or disorder, for biomedicine, when the body is healed, order is re-established. Among the traditional doctors whom I have interviewed, the question that always cropped up was that the harmony, the well-being of an individual, is a reflex of the well-being of the group, of the network of friends and relatives, and that illness alters the relationship of the individual with others. In this sense, while studying a specific case, the "*nyàngà*" promotes the reintegration of the individual into the solidaristic interplay of group interests, seeking to control emerging conflicts so as to ensure the maintenance of the group. As Lewis Carroll (1977) would say, there has to be continuous movement for the group to maintain itself as it is.

Another factor to keep in mind is that of contamination, since frequently an illness—if it results from the contagion of "unsatisfied" spirits, and if it is not effectively treated—can affect other members of the group. If obligations to ancestors are not fulfilled, they can withdraw protection from an individual, a family, or even a community, since their spirits continue to be a part of the family structure. The ailment caused by this absence of protection is seen as a demand made by ancestral guardians that broken ties be

re-established, thus calling attention again to the question of witchcraft as a regulatory system of social imbalances.

The considerable dynamics of traditional medical action can be contrasted with the Ministry of Health's[43] project of collaboration with practitioners of traditional medicine, a part of its health policy (Jurg *et al.*, 1991; FRELIMO, 1999). The system of public health developed by the state after independence places special emphasis on prevention. It seeks to reach the majority of the population, rural or peri-urban, through the establishment of a vast network of basic health units and agents capable of offering elementary healthcare, as well as by promoting health through education and the improvement of conditions of hygiene. The effect of such policies depends in the first place on the participation of the targeted populations.[44] For this reason, the WHO (1978) has recommended the inclusion of "practitioners of traditional health" within national health systems. Since this policy considers populations as partners in its implementation and not merely as passive recipients, the rehabilitation of local therapists, who have long been directly involved in such practices within communities, is essential.

The state has been using this justification to legitimize its interest in so-called traditional medicine, although this alone does not explain the underlying ambiguities that affect both the notion of valorizing "traditional medicine" and the practical experiments that are recommended. In promoting a discourse that supports the integration of traditional medicine with modern medicine, the state and WHO itself (Jurg, 1992; Monekoso, 1994; World Bank, 1994; Aregbeyen, 1996; WHO, 1996; Friedman, 1996) aim to remove from traditional therapists the control over the treatment (in its various forms) of the majority of the population. In supporting the formalization of "traditional medicine" according to the tenets of modern medicine, the former is circumscribed into a collection of empirical knowledge (medicinal plants, pharmacopoeia, and practical know-how), physical techniques and epidemiologies (Tomé, 1979; Marrato, 1995; Lambert, 1997). The knowledge of the traditional doctor is only seen to be valid as a complement to biomedicine; further, the traditional doctor is seen as one who needs to be trained, but who does not participate in the training of biomedical doctors (Nordstrom, 1992; Cunningham, 1995). This fact has resulted in a certain condescending resentment among traditional doctors: "We have no bitterness toward them [i.e., practitioners of modern medicine] but we also want recognition; they have to respect us [. . .]; we want to work with them, but also to teach what we know: it is not just plants."[45]

All these aspects suggest that we should make a deeper evaluation of the importance and legitimacy of different bodies of knowledge.

THE IMPORTANCE OF TRADITIONAL MEDICINE

Between legitimation and legitimacy

It is necessary to conduct a brief analysis of the privileged role of the state, the arbiter that attributes to itself the special status of establishing the rules as well as of playing the game. By looking at who is authorized and/or favored by the state, what knowledges are tolerated or suppressed, what practices are recognized or even ignored, it is possible to get a stronger and clearer idea of the logic of the state's action. This implies analyzing the fields of power from the point of view of the social recognition of different categories of health practitioners, in the complex interplay between competition and complementarity (Fassin and Fassin, 1988).

For the state, in the present as in the past, the delimitation of what is knowledge and magic, of the official and the non-official, is done according to normalized practices that the state itself controls. In the perspective of rational legitimation imposed by the colonial system, only those who study in formal institutions of learning are authorized to practice medicine. This must have been one of the main reasons that led many traditional doctors, at the beginning of the 1990s, to establish their own association (AMETRAMO).

People legitimate the health practitioners that they consult, whether those practitioners are trained in biomedicine or in so-called traditional medicine. Usually, traditional legitimacy is spontaneously associated with the "*nyànga*" and rational legitimacy with the modern doctor (depending on his/her certificates). The acceptance of traditional doctors depends on the loyalty and confidence of those who recognize them as the inheritors of wisdom. Their legitimacy, the recognition of their competence within a field of knowledge, is ensured by those who constantly consult them. Among the traditional doctors themselves, legitimacy is reinforced by belonging to and sharing an ancestral knowledge, which is retrieved during the "visitations" of the spirits. The commitment to curing a patient as well as the ethical behavior of the traditional doctor reflect on his/her professional success: "When you do good work, it becomes known. People know that I can cure illnesses; they come from long distances [. . .]. They have heard of a healer in Maputo who cures this or that illness. That is how people know that I can heal properly, because I've healed many people."[46]

One of the most notorious forms used by biomedicine to disqualify traditional medicine lies in the characterization of the latter as an illegal practice, as well as in demonstrating the absence of "scientific" procedures (such as experimentation) or the lack of an understanding of epidemics or contagion (Polanah, 1967–68; 1987; Junod, [1917] 1996). All these factors confirm the "local" negative characterization of traditional medicine from the modern

"scientific" point of view, which in effect omits references to their work procedures so as to bolster the "scientific" status of biomedicine. However, work on and with traditional doctors has shown that there is a continuous process of inquiry and search for new medicines and solutions, as well as the exchange of information among therapists. All of this implies the existence of experimentation, which, furthermore, is not a recent phenomenon:

> My grandfather, who was a well-known doctor in his time, taught me to heal as a child [. . .]. When he died, I devoted myself to the studies he left, doing various experiments, first with dogs, then with cats, and after being convinced of the usefulness of these medicines, I applied them to treat illnesses arising in our family. Thus I came to be known as a doctor many years ago [. . .] and I saved many people from certain death, acquiring more practical experience from my work and, due to my patience and tenacity, I came to enjoy a great reputation (Madão, [1921] 1971: 9).

What stands out in this brief historical analysis is that traditional medicine seems to be able to adjust to new therapeutic systems, seeking to negotiate positions and maintain or gain recognition and status, while biomedicine is still searching for ways and means to demonstrate its competencies.

The vitality of traditional medicine

The various attempts to suppress traditional medicine, or at least to limit its practice to "uncivilized native subjects," led to changes in the traditional doctors' field of action, a process that in fact constitutes evidence of the extraordinary capacity of this medicine to adapt itself and appropriate the mechanisms created by the state for its own benefit (Meneses, 2000). Like any attempt at social imposition, this type of interference has resulted in periodic crises of vulnerability.

With the implantation of the colonial system, the Portuguese state attempted to eliminate traditional therapists, condemning their activities as superstition and magic (di Celerina, 1846; Cunha, 1883; Junod, [1917] 1996; Silva Tavares, 1948). This resulted in the imprisonment and banishment of numerous "healers," particularly during the 1920s and 1930s. However, because of the scarcity of doctors and nurses in the territory, the colonial state rapidly came to accept the presence of healers, since it could not provide for the healthcare needs of the population:

> Indigenous medicine has been and must continue to be tolerated while medical assistance cannot fully reach all the villages of the interior [. . .]. If ancestral medicine has to be tolerated in some areas of the colony, it would not be logical to use full punitive sanctions in respect of the clinical errors of *nyàngàs* of good faith. Apart from this, in a certain way, they should be considered useful in their social milieu because, with the lack of a better medicine, what they do is not so abominable (Gonçalves Cota, 1946, Art.68).

As a result of the fragility of the Portuguese colonial system, traditional doctors were able to request and obtain formal authorization (by the state) to act as therapists in areas where there were no practitioners of modern medicine, or where confidence in these was not very high.[47]

In the period immediately after independence (late 1970s and 1980s), the first movement of traditional therapists attempted to gain more space for action. Among the proposals made in 1975 by a group of traditional doctors to the Transitional Government Commission for Restructuring Health Services[48] was the creation of a School of Tropical Medicine to train more traditional practitioners. This was refused, in the period after independence, "because traditional medical practices are limited to empirical knowledge mixed with obscurantism. The official recognition of a healers' organization would amount to the institutionalization of obscurantism [. . .]. This implied the practice of private medicine, which was not legal at the time."[49]

Because it was important "to make use of the knowledge, but not the person, for the attitude of the person was obscurantist,"[50] and as a result of pressure exerted by various traditional practitioners on government and FRELIMO party organs, the National Directorate of Preventive Medicine at the Ministry of Health was given the task of creating the necessary means to research and collect plants used by traditional health practitioners (Castanheira, 1979; Tomé, 1979). At a juncture in which the field of action of healers was severely limited, the collection of plants and discussion of their use with the GEMT and INIA[51] was one of the few possibilities for the continuation of their activity, albeit with a semi-legal character.

Although the traditional doctors expected greater openness, since "now the country was finally ours,"[52] both doctors and magistrates of the post-independence period, due to their western education and the political objectives of the time, looked on witchcraft and the practices of healers as a shameful phenomenon. It was necessary to abandon them in order to construct a new knowledge, free of superstition and obscurantism. Once again, in the post-independence period, the state emerged as the unwitting ally of witchcraft by maintaining the prohibition of ordeals and legitimizing their application by traditional authorities and institutions.[53] If in the colonial period some forms of practice by traditional doctors were still permitted, now their prohibition was instituted, with healers being persecuted (even those who could solve cases of witchcraft and cure people). In this hostile

environment, "traditional therapists" were now called "obscurants," with old mentalities (Castanheira, 1979; Tomé, 1979; Machel, 1981; Serviços de Nutrição, 1981).[54]

In M. F. Zimba's words, this was a very difficult period, and only the formation of an association of traditional doctors could alter the situation:

> Early on I went to talk with Machel [the first President of Mozambique] to help us get organized. It was necessary to organize ourselves so as to work properly, to avoid prosecution [. . .]. He sent me to talk with Hélder Martins [the then Minister of Health]. He was not helpful [. . .], he threatened us, but I kept insisting [. . .]. Then we managed to set up the Office for Support to Traditional Medicine. I worked a lot with Leonardo Simão [a doctor, and the present Minister of Foreign Affairs] in his office in the Ministry. Afterwards I stopped working there. At present I am working at home.[55]

At the end of the 1980s, with the introduction of neoliberal policies, the opening toward traditional medicine widened, until in 1991 the practice of private medicine was liberalized. As I mentioned, this made possible the formation of AMETRAMO—the Association of Mozambican Traditional Doctors.

The state and AMETRAMO

The evaluation of the traditional should not be seen only from the legal and formalistic position of the state. Several traditional therapists mentioned that it was common to meet with their seniors—the *mab'ava*—in order to analyze problems about which they were uncertain, a practice that is currently being reinforced by AMETRAMO.[56]

Thus, AMETRAMO has not come to fill a totally empty space in the relations between traditional therapists. During the meetings ("*mavandla*"[57]) for the graduation of the "*mathwasana*," the therapists come together to discuss the matters affecting them. AMETRAMO has merely reinforced and amplified these connections. Another important aspect is the constitution of AMETRAMO as a space for claiming social recognition for traditional medicine. In this case, the members of the association show themselves to be not in a position of weakness, but one of strength, due to the social role they represent. The concern of the current leadership of AMETRAMO in acting as the representative for the interests of all Mozambican traditional doctors in the rehabilitation of traditional medicine contributes toward its own legitimation; the power that derives from this representation acts as a confirmation of their concern and as a means of achieving their objective.

The paradox that many insist constitutes an obstacle to development—the persistence of "traditional" values—should not be seen as an antinomy.

Traditionalism is only what it is to the extent that it is distinguished from modernity by difference, but in fact it continuously feeds on modernity. Encounters occur at various levels: the state ignores traditional doctors while its functionaries frequently resort to them; the medical and law faculties do not recognize their knowledge, while many nurses and other medical personnel and lawyers do not hesitate to consult these therapists. This paradox is only an apparent contradiction: the norm established and imposed by the state is based on a legal and rational model of legitimacy. The agents that make up these institutions, on the contrary, dispense with these principles when acting as patients, obeying only practical rules. As one of the patients told me, "anything goes, you never know if they will work, but one certainly will; we just cannot risk not doing so."[58] For the patient, the need for legitimacy diminishes in the face of an ailment, social problems, or misfortune. When they consult a traditional doctor to solve a problem or cure an ailment, the university professor, the minister, or the lawyer are not considering the question of legitimacy, but looking for a practical effect. For this reason, it is impossible to divide society into "traditional" and "modern" in terms of medicine and the search for healing. The "civilized" businessman and the peasant woman with a sick child have similar itineraries, differing only in the financial means involved, and, consequently, in the prestige of the traditional practitioners consulted.

WHERE IS THE ALTERNATIVE?

Returning to the beginning of this text, I pose the same question: is traditional medicine really an alternative to biomedicine? The argument developed to this point leads to the suggestion that the struggle of biomedicine for a limited incorporation of traditional medicine (only in the restricted sense of medicines and techniques), as well as its resistance to the recognition of the wide spectrum of efficacy of traditional medicine, are really a recognition of the strength of this other medicine, which is called, by opposition, traditional. The major reason for the tremendous vitality of traditional medicine seems to lie in the fact that "traditional medical institutions" treat disease and at the same time resolve society's problems, whether they are related with order (representations, norms) or with conflicts (tensions, collective misfortune). They are figures of modernity, but of another modernity, not imposed but composed of compromises with previous orders. Far from embodying the stasis of tradition, traditional medicine feeds on an eminently problematic modernity, appropriating the gaps and metamorphoses created by the state and giving them new meanings. Traditional medicine acts as a regulatory factor of social rhythms, resolving tensions and ensuring the reproduction of the social fabric.

The main focus of interpretation consists in demonstrating that modernity is not over, that it does not cease to amplify the "noise" of the traditional. If the treatment of illness is necessarily based on the therapeutic efficacy of symbolic and interpretative procedures, other forms of intervention give it a greater scope. Apart from treating different manifestations of misfortune (failure at school, marital difficulties, financial problems), the traditional doctor also operates in the preventive field, guaranteeing his clients means of protection against various sources of harm. In this sense, the traditional doctor ensures development, inserting him/herself into the heart of a modernity that, through individual aspirations and strategies, attempts to break with previous logical orders. It is for this reason that traditional medicine continues to attract not only patients from rural areas, or the economically disadvantaged; rather, patients from the urban areas increasingly come with their problems and expectations, seeking treatment, protection, success, things which all believe are possible and practicable. One can thus legitimately speak of a counter-hegemonic form of knowledge and power, in which this medicine represents the dynamics and the poles of locally used power.

In order to answer the initial question—whether traditional medicine is an alternative to biomedicine—I think it has been made clear that the strength of this field of knowledge lies in its ability to make use of modernity and modify it according to its needs. The alternative lies not in "other knowledges," classified as complementary, but in a complex interaction between different knowledges, all legitimate in the eyes of those who resort to them and sanction them as a form of power. Inter-medicine is thus synonymous with multiple medical knowledges, which are applied in different spheres—the family, the community, the workplace, and the public sphere of citizenship—thus granting it an emancipatory character.

Would not the recognition of AMETRAMO by the state, via its legalization, thus imply the impossible task of imposing a version of modernity that is exogenous to the one present in the social terrain? For the public powers (both at a national and international level), the political bet seems to favor the valorization and pseudo-legitimation of traditional medicine, refusing, however, to acknowledge the social dimension of this medicine by restricting it to the simple application of drugs and plants.[59] The constant attempts by the state to "promote and valorize" traditional medicine—as a complementary alternative to biomedicine—lead to another point of tension and conflict, the result of efforts to control politically the communities where this knowledge is produced. However, the complexity, fluidity, and ambiguity of the meanderings that compose the social field of traditional medicine make this process very difficult, if not impossible. In normalizing traditional therapeutic processes, in reducing this knowledge to written form, which is repetitive and allows for little innovation, are we not putting into question precisely that ambiguity that is so essential to the dynamic of traditional medicine's transformation and creative appropriation of modernity?

The emancipatory character of inter-medicine derives from its being "under construction" at a stage in which traditional medicine is experiencing a turbulent process of transition while trying to produce "another modernity." In this process, it is the echoes and marks of the traditional world that are most noticeable because they are at odds with "classic Western modernity." The constellation of distinct knowledges that is being created among different therapeutic realities leads to the reinforcement of their performance and legitimacy, as well as to a greater reciprocal control. This mosaic of heterogeneous knowledges thus emerges as a guarantee of a permanent and open dialogue "in progress," as an exercise of democratic power/knowledge, justifying its emancipatory character. Hence, based on the local forms of resistance, one needs to present the different actors and their contexts of struggle, to build connections between these actors, mobilizing them and supporting their campaigns for a more egalitarian inclusion in the struggle for the diversity of knowledges, for achieving a broader space of action, and for enlarging the shared fields of knowledge. This unity based on difference should constitute one of the cornerstones of the elaboration of a new global counter-hegemony.[60] This kind of research necessarily has to be directed towards political intervention and towards the transformation of contemporary societies.

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Notes

1 Here I follow Santos's approach (2000), which refers to similar situations as examples of "globalized localism."
2 The death of local knowledge by an alien science (Santos, 1998a: 208).
3 This subject is also discussed by Xaba (2000), who makes a critique of the negative impact of modern scientific medicine on South African indigenous medical knowledges.
4 Here I follow Santos's theoretical proposal on "interlegality" (see Santos, 1987; Santos and Trindade, 2000), broadening it and projecting it beyond the field of justice to that of health.
5 Associação Moçambicana de Médicos Tradicionais (Mozambican Association of Traditional Doctors).
6 See also Borges Coelho's text (2001), which focuses on the question of rival knowledges in the prevention of natural disasters from the national/local perspective.
7 C. Tamele, personal interview, June–July 2000.
8 In Africa, much has been written on the place of the "traditional" in current epistemological discussions (see Hobsbawm, 1988; Copans, 1990; Gentili, 1999; O'Laughlin, 2000; Santos and Trindade, 2000). In other political contexts, the debate between the "modern" and the "traditional" is seen either as a space of conflict from which new realities can emerge (for India, see Visvanathan, 2000), or as the basis for the creation of spaces of difference and contrast (Flórez, 2000; Xaba, 2000).
9 Personal interview, May 2000.
10 It also happens that imported religions (Christianity and Islam) have generated syncretic movements whose specificity lies in the fact that their religious work includes therapeutic functions, which contribute further to the range of therapeutic options available. Between the local medicines and syncretic movements there is no necessary continuity or proximity; rather, they are examples of the enormous diversity of therapeutic resources currently available for responding to problems of crisis and order in existing structures (see Schoffeleers, 1991, Honwana, 1996, Cruz e Silva, 2000).
11 First the colonial, and subsequently the post-colonial, state (i.e., after 1975).
12 Ministries, medical and law faculties, etc.
13 Gabinete de Estudos de Medicina Tradicional (Office for the Study of Traditional Medicine), founded in the Ministry of Health to promote links with traditional medicine (Serviço de Nutrição, 1981). In a conversation with the director of GEMT, A. Agostinho (a biochemist), the continuity of state policy concerning traditional medicine became evident (May 2000).
14 M. F. Zimba, personal interview, August 2000.
15 In the logic of biomedicine, health has to be understood in the wider context of the development of a country, region, or community (WHO, 1996).

16 A. Fabião, personal interview, April 2000.
17 A. Boane, personal interview, March 2000.
18 P. Salomão, personal interview, July 2000.
19 Another form of discredit is based on the use of the term "*curandeiro*" (healer), which for many practitioners of traditional medicine in Maputo city is synonymous with witchdoctor. Thus, in order to claim powers similar to those of the practitioners of biomedicine, such healers demand to be called "traditional doctors."
20 M. Suzana, personal interview, February 2000.
21 Extract of an interview with Amida Safar Gina, traditional doctor (*Domingo*, 13 January 1991).
22 Tique, 2000.
23 I.e., the "*tinholo*," the divination bones used by traditional doctors as auxiliary means of diagnosis.
24 L. Augusto, personal interview, May 2000.
25 See the case study of AMETRAMO below.
26 In southern Mozambique, the native term used for traditional doctors is "*nyàngà*," (Galvão da Silva, [1790] 1955; Simões Alberto, 1965, etc.) The "*nyàngàrùme*" is the herbal doctor who uses plants for treatments, without resorting to spiritual forces to help solve problems (Temba, 1992).
27 M. F. Zimba, personal interview, June 2000.
28 H. Macie, personal interview, February 2000.
29 During the training process the individual remains isolated from his/her family, maintaining few or even no contacts at all with them, even when he/she is married and has children.
30 See also Honwana (1996) and Temba (2000). The latter evaluates the question of traditional doctors from a gender perspective.
31 C. Tamele, personal interview, May 2000.
32 As stated in several texts, one of the main characteristics of "traditional knowledge" seems to be its ancestral roots, which are maintained and transmitted from generation to generation with the support of dead kin (Flórez, 2000; Xaba, 2000).
33 A student of traditional medicine.
34 A term of respect applied to a very wise and esteemed person. In the context of this study, it refers to an experienced or senior traditional doctor, male or female, who has students.
35 P. Cossa, personal interview, June 2000.
36 Hence the fact that many illnesses are explained as "the head aches" or "the leg hurts."
37 Prayers to ensure the maintenance of connections with the ancestors.
38 Plural of "*nòyì*." The *nòyì* is a spirit with evil power, who can even provoke trouble from a distance, through the help of somebody whose body he uses. Usually the *valòyì* act at night, through the introduction of alien parts (bones, blood) into somebody's body; as a consequence, the person withers and dies. During the day, the evil spirit can act through elements he has previously contaminated. The *nòyì* can still use a person whose body he "opened" and penetrated, enslaving him/her. These people can be transformed into animals, such as leopards, hyenas, and serpents, or be forced to work in

the fields for this spirit, or to steal goods to feed the spirit (Muthemba, 1970; Polanah, 1987; Honwana, 1996).

39 I.e., to "sniff out" the evil spirits, so as to get hold of them, since they are the origin of the problem. The spirit can only be identified by its odor, and this explains the need to "sniff out" the souls of unsatisfied ancestors or of the *valòyì*.

40 Interview with C. Tamele, March 2000.

41 Plural of "mùrhi," i.e., "plants." In a broader sense, it also means medication.

42 M. Yussufo, personal interview, December 1999.

43 The state entity that is most directly related with traditional medicine.

44 It should be mentioned that in Maputo, in terms of provision of hospital care in modern medicine, there is a ratio of one doctor to 48–50,000 inhabitants, while the ratio of traditional doctors to patients is one to 1000–1500, a situation that is similar to other countries in the region.

45 M. F. Zimba, C. Tamele, and P. Cossa, collective interview, September 2000.

46 M. F. Zimba, personal interview, April 2000.

47 More censured and persecuted was the practice of "ordeal," i.e., a test of guilt or innocence, which was prohibited according to the precepts of Portuguese justice.

48 I am grateful to L. Meneses for this information.

49 H. Martins (the first Minister of Health in independent Mozambique), personal interview, March 2000.

50 *Ibidem*.

51 Instituto Nacional de Investigação Agronómica (National Institute for Agronomic Research).

52 M. F. Zimba, personal interview, March 2000.

53 This was equivalent to forbidding the identification and punishment of those individuals considered to hold "evil knowledge," regarded as a source of social instability and therefore harmful to society (see note 51)

54 Several of them were sent to distant forced labor camps, the so-called "re-education camps."

55 M. F. Zimba, personal interview, June 2000.

56 C. Tamele, personal interview, April 2001.

57 *Vandla*—assembly, gathering, meeting (lit.). Here, the word refers to a group of traditional therapists who had or still have the same *b'ava*; it also refers to larger gatherings of traditional doctors, called to discuss subjects relating to the "health" of a given community.

58 A. Boane, personal interview, March 2000.

59 In 2004, the Mozambican government recognized traditional medicine as an integral part of the national health system.

60 Research as action, as an exercise in citizenship, is analyzed following Santos's suggestion (2000).