From Rural Gift to Urban Commodity
Traditional Medicinal Knowledge and Socio-spatial Transformation in the Eastern Lake Victoria Region.

Anne Ouma
Gerum-kulturgeografi 2013:1

Institutionen för geografi och ekonomisk historia
Umeå Universitet
90187 Umeå
Sverige

Department of Geography and Economic History
Umeå University
SE-90187 Umeå

Tel: +46 90 786 5696
Fax: +46 90 786 6359
http://www.geoekhist.umu.se
E-mail:
anne.ouma@geography.umu.se
anncofm@yahoo.com

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Anne Ouma

Umeå, October 2013
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Abbreviations, acronyms and glossary

ABS Access and benefit sharing
ARIPO African Regional Intellectual Property Rights Organization
CAM Complementary and Alternative Medicine
CBD Convention on Biological Diversity
COSTECH Tanzania Commission for Science and Technology
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CTMDR</td>
<td>Centre for Traditional Medicine and Drug Research</td>
</tr>
<tr>
<td>DC</td>
<td>District Commissioner</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus group discussions</td>
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<tr>
<td>FEMNET</td>
<td>African Women’s Development and Communication Network</td>
</tr>
<tr>
<td>GT</td>
<td>Grounded theory</td>
</tr>
<tr>
<td>GR</td>
<td>Genetic Resources Unit</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus infection/ acquired immunodeficiency syndrome</td>
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<tr>
<td>HUPEMEF</td>
<td>Huruma Peace Mercy Foundation</td>
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<tr>
<td>IDRC</td>
<td>International Development Research Centre, Canada</td>
</tr>
<tr>
<td>ICGLR</td>
<td>International Conference on the Great Lakes Region</td>
</tr>
<tr>
<td>IHI</td>
<td>Ifakara Health Institute</td>
</tr>
<tr>
<td>IK</td>
<td>Indigenous Knowledge</td>
</tr>
<tr>
<td>IKAP</td>
<td>Indigenous Knowledge and Peoples Network</td>
</tr>
<tr>
<td>INR</td>
<td>Institute of Natural Resources, Kwa Zulu Natal South Africa</td>
</tr>
<tr>
<td>IPP</td>
<td>East Africa Largest Media Conglomerates Society</td>
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<tr>
<td>IPW</td>
<td>Intellectual Property Watch</td>
</tr>
<tr>
<td>IP</td>
<td>Intellectual property</td>
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<tr>
<td>IPR</td>
<td>Intellectual Property Rights</td>
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<tr>
<td>IRDNC</td>
<td>Integrated Rural Development and Nature Conservation-</td>
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<tr>
<td>NAMIBIA</td>
<td></td>
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<tr>
<td>KAS</td>
<td>Kagera Albinos Society</td>
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<tr>
<td>KEFRI</td>
<td>Kenya Forestry Research Institute</td>
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<tr>
<td>KEMRI</td>
<td>Kenya Medical Research Institute</td>
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<td>KENRIK</td>
<td>Kenyan Resource Centre for Indigenous Knowledge</td>
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<td>KANU</td>
<td>Kenyan African National Union</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>KENMOFA</td>
<td>Kenya National Farmers’ Association</td>
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<td>KIPI</td>
<td>Kenya Industrial Property Institute</td>
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<td>KSH</td>
<td>Kenya Shillings</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>NAI</td>
<td>The Nordic Africa Institute</td>
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<td>NBI</td>
<td>Nile Basin Initiative in Mwanza</td>
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<tr>
<td>NEMBA</td>
<td>National Environmental Management Biodiversity Act</td>
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<tr>
<td>NEMC</td>
<td>National Environment Management Council of Tanzania</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NTFP</td>
<td>Non Timber Forest Products</td>
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<tr>
<td>OCPD</td>
<td>Officer Commanding Police Division</td>
</tr>
<tr>
<td>PCD/RCO</td>
<td>The Planning Commission of Dar es Salaam/Regional Commissioner’s Office</td>
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<tr>
<td>POs</td>
<td>Participant Observations</td>
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<tr>
<td>SASC</td>
<td>South African San Council</td>
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<tr>
<td>SAFINA</td>
<td>Safina Non-Governmental Organization</td>
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<tr>
<td>STDs</td>
<td>Sexual Transmitted Diseases and Infections</td>
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<tr>
<td>SSIs</td>
<td>Semi-Structured Interviews</td>
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<tr>
<td>Sis</td>
<td>Structured Interviews</td>
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<tr>
<td>TGNP</td>
<td>Tanzania Gender Networking Programme</td>
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<td>TK</td>
<td>Traditional Knowledge</td>
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<td>TBA</td>
<td>Traditional Birth Attendants</td>
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<td>THs</td>
<td>Traditional Healers</td>
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<tr>
<td>TKDL</td>
<td>Traditional Knowledge Digital Library</td>
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<td>TM</td>
<td>Traditional Medicine</td>
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<td>TMK</td>
<td>Traditional Medicinal Knowledge</td>
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<td>TNC’s</td>
<td>Transnational Co-operations</td>
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TSH Tanzania Shillings
TAWG Tanga AIDS Working Group
TAS Tanzania Assistance Strategy
TB Tuberculosis
TANU Tanganyika African National Union
THETA Traditional and modern health practitioners together against AIDS and other diseases
TASO The AIDS Support Organization of Uganda
TMSEE Traditional Medicine for Social and Economic Empowerment
TRIPS Trade-Related Aspects of Intellectual Property Rights
UNAIDS The Joint United Nations Programme on HIV/AIDS
UNDP United Nations Development Programme
UNDP-GEF United Nations Development Programme Global Environmental Facility Programme
UNESCO United Nations, Educational Scientific and Cultural Organization
UNCTAD United Nations Conference on Trade and Development database COMTRADE
USD United States Dollars
UN ECOSOC United Nations Economic and Social Council
UN SWIP UN Report on The State of the World’s Indigenous Peoples
UN FAO Food and Agriculture Organization of the United Nations
WHO World Health Organization
WTO World Trade Organization
WIPO World Intellectual Property Organization
<table>
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<tr>
<th>Word</th>
<th>Description</th>
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<tr>
<td><em>Aina</em></td>
<td>Types, nature, species, kind (Dholuo)</td>
</tr>
<tr>
<td><em>Awangi</em></td>
<td>Condition of burning feeling over the body (Dholuo)</td>
</tr>
<tr>
<td><em>Basi</em></td>
<td>So; It is okey (Kiswahili)</td>
</tr>
<tr>
<td><em>Chang’aa</em></td>
<td>Locally brewed alcohol (Dholuo)</td>
</tr>
<tr>
<td><em>Cholo</em></td>
<td>To aid women in child birth (Dholuo)</td>
</tr>
<tr>
<td><em>Chomo</em></td>
<td>Literally means to ‘join’. Bone setting (Dholuo)</td>
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<tr>
<td><em>Dani</em></td>
<td>Literally means Grandmother. Term refers to an older woman who is advanced</td>
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<td></td>
<td>in age and has acquired the status of grandmother. Also used as an endear-</td>
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<td></td>
<td>ing term for a younger girl/lady.</td>
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<tr>
<td><em>Dholuo</em></td>
<td>Language spoken by majority in Nyanza</td>
</tr>
<tr>
<td><em>Fitina</em></td>
<td>Idle talk (Dholuo, Kiswahili)</td>
</tr>
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<td><em>Gonyo</em></td>
<td>‘To untie’. Initial payment /installments (Dholuo)</td>
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<td><em>Juogi</em></td>
<td><em>(Juok singular)</em>. Spiritual entities (Dholuo)</td>
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<td><em>Jaasthma</em></td>
<td>A patient with asthma (Dholuo)</td>
</tr>
<tr>
<td><em>Jatuberculos</em></td>
<td>A patient suffering from tuberculosis (Dholuo)</td>
</tr>
<tr>
<td><em>Ka nyamera</em></td>
<td>At my sister’s home (Dholuo)</td>
</tr>
<tr>
<td><em>Kichaa and Kifafa</em></td>
<td>Insanity and mental disorders (Kiswahili)</td>
</tr>
<tr>
<td><em>Kipaji</em></td>
<td>Brilliant, a gift, talent (Kiswahili)</td>
</tr>
<tr>
<td><em>Kushirikiana</em></td>
<td>To cooperate (Kiswahili)</td>
</tr>
<tr>
<td><em>Kuugua</em></td>
<td>To be ill (Kiswahili)</td>
</tr>
<tr>
<td><em>Mizimu</em></td>
<td>Spiritual entities (Kiswahili)</td>
</tr>
<tr>
<td><em>Mzungu</em></td>
<td>White man, European (Kiswahili)</td>
</tr>
<tr>
<td><em>Mpunga</em></td>
<td>Rice (Kiswahili)</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>MKURABITA</strong></td>
<td>Tanzania Property and Business Formalization Programme (Kiswahili)</td>
</tr>
<tr>
<td><strong>Mira</strong></td>
<td>Traditional knowledge (Kiswahili)</td>
</tr>
<tr>
<td><strong>Mzange</strong></td>
<td>A type of medicinal tree (Kisukuma)</td>
</tr>
<tr>
<td><strong>Mzee</strong></td>
<td>Husband in the home or an old/elderly man</td>
</tr>
<tr>
<td></td>
<td>An endearing term for a young boy (Kiswahili)</td>
</tr>
<tr>
<td><strong>Mzizi</strong></td>
<td>Roots (Kiswahili)</td>
</tr>
<tr>
<td><strong>Mugariga</strong></td>
<td>A type of medicinal tree (Kiswahili)</td>
</tr>
<tr>
<td><strong>Ndawa</strong></td>
<td>A type of medicinal plant (Dholuo)</td>
</tr>
<tr>
<td><strong>Nga’ maochuogi yath</strong></td>
<td>Someone who has been ‘pierced’ with evil medicine (Dholuo)</td>
</tr>
<tr>
<td><strong>Ngou</strong></td>
<td>A type of medicinal plant (Dholuo)</td>
</tr>
<tr>
<td><strong>Nyaluo</strong></td>
<td>The daughter/mother of Luo (Dholuo)</td>
</tr>
<tr>
<td><strong>Nyuguyu</strong></td>
<td>A type of medicinal tree (Kiswahili)</td>
</tr>
<tr>
<td><strong>Okita</strong></td>
<td>A type of medicinal plant (Dholuo)</td>
</tr>
<tr>
<td><strong>Okoth/Akoth, Koth</strong></td>
<td>Male/female born during Rains, Rain (Dholuo)</td>
</tr>
<tr>
<td><strong>Oketch/Aketch, Kech</strong></td>
<td>Male /Female born during famine, Famine (Dholuo)</td>
</tr>
<tr>
<td><strong>Okinyi/Akinyi, Go Kinyi</strong></td>
<td>Male /Female born during hours, Morning (Dholuo)</td>
</tr>
<tr>
<td><strong>Ohuya</strong></td>
<td>A type of medicinal plant (Dholuo)</td>
</tr>
<tr>
<td><strong>Operation Vijiji</strong></td>
<td>The settlement or re-settlement approaches of people in villages (1970 to 1977) in line with the Villagization policy (Kiswahili)</td>
</tr>
<tr>
<td><strong>Ralam yath</strong></td>
<td>A token prayer (Dholuo)</td>
</tr>
<tr>
<td><strong>Shing’wengwe and Shishieg’we</strong></td>
<td>Ogres and spirits (Kisukuma)</td>
</tr>
</tbody>
</table>
**Sangomas**  Therapist, Healer, Shaman, Traditional Healer  
(South African languages)

**Shamba**  Parcel of land used for agricultural purposes. Term used by urban residents to describe rural Home (Kiswahili)

**Tambika**  Offer, sacrifice (Kiswahili)

**Ujamaa**  Term used for the villagization of communities across the country. *Ujamaa* literally means family ties (Kiswahili)

**Uhuru**  Freedom (Kiswahili)

**UKIMWI**  AIDS (Kiswahili)

**Uganga**  Divination by TH’s (Kiswahili)

**Waganga**  (Singular *Mganga*) doctor (Kiswahili)

**Wazee wa mira**  The Elders who hold TK and customs and transmit this knowledge (Kiswahili)

**Watemi**  Chiefs (Kisukuma)

**Chira**  Chira is a punishment, sin-consequences in the form of persistent illness and wasting disease sometimes culminating in death brought on by something done wrong, wicked acts, someone close to the victim who may have incurred or ignored (not necessarily consciously) some kind of relationship taboo, and breaking the norms that have regulated community life for centuries. The concept among the Luo broadly stands for a range of misfortunes that tear apart community and manifest in natural catastrophes, such as famines, droughts, illnesses (Dholuo)

**Ubuntu**  An African ethical or humanist philosophy focusing on people’s allegiances and relations with each other; description of attempts by African societies to seek “interdependence, interrelationships and an interconnectedness of all phenomena” (Zulu/Xhosa)
1. Introduction - setting the scene

My Grandmother, Clementina Ongaro, to whom I will henceforth refer as Dani\(^1\), was born in 1917 in the then South Nyanza District of Kenya, along the shores of the Eastern part of Lake Victoria. This was during the height of colonial Kenya, where missionaries were active in establishing mission schools and hospitals in the region while the Kenyan colonial project was firmly in place. Dani was born into a family of many boys and girls, with seven siblings surviving into adulthood, and she herself would give birth to 15 children. As a young girl, she was aware that her family was descended from traditional healers (THs). In my discussions with her in the latter part of 2007, when I had started my PhD studies, she told me how she made her entrance into the life of a TH. Dani related that during the 1960s she accompanied her elder sister Isabella, by then a well-known healer in the Lake Victoria Region in both Kenya and Tanzania, to the border town of Sirare which sits astride the Kenyan and Tanzania border. A Luo\(^2\) musician called Owino was to perform, and they went to watch his show. Owino got food poisoning and Dani was the one who through the medicine she had carried saved his life.

He wanted to sing immediately and to compose a song in my praise. But I told him: No, it’s not me; it’s Bella who is the elder one whom you should compose a song about. I have the Spirit of God which has helped to restore you to life … but you should not compose a song to me, it’s Bella who is older...

Dani then sang the song, the musician composed in honour of Isabella, which was also dedicated to her and which to Dani was an important mark that she was now a recognized TH:

The female Traditional Healer Isabella who hails from Asego. People have failed to understand your character. Isabella resurrects what the Almighty arranged a long time ago.

Approximately 60 years have passed, since she entered the profession and changes such as urbanization, migration, and monetization of traditional

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\(^1\) Dani literally means Grandmother. It is a Luo term referring to an older woman who is advanced in age and has acquired the status of grandmother. It can also be used as an endearing term for a younger girl/lady by an older one.

\(^2\) Luo-The majority of the population comprise this ethnic group living in Nyanza.
medicinal knowledge (TMK), as well as historical changes, have profiled this region. Dani began as a TH in her 20s during the time of the colonial period in East Africa. She was still practicing her profession until she passed on in 2008, and in today’s independent Kenya, socio-spatial transformations have changed the landscape which dictates how she met and treated her patients when they came to her home. Urban residents from far and wide - Tanzania, Mombasa, including youth, urban elite, relatives and rural people visited her in search of cures and treatment for numerous ailments, many of which are closely related to the changing socio-spatial issues in this region.

1.1 The research problem

For all the revolutionary changes in human health care in the 21st century, life in many parts of Africa begins with and is sustained by the support of TMK (WHO 2003). TMK, which includes the identification of plant species with medicinal properties and their use, has been developed by and handed down to subsequent generations over millennia. According to Battiste (2002) the 1970s, as well as the last decade of the 20th century, witnessed an explosive growth in academic publications on the relevance of indigenous knowledge and its pedagogies, including its relevance in a variety of policy sectors and academic disciplines. While the use of TMK is widespread throughout rural and urban Africa, it is evident that its usage is rapidly changing due to intense socio-economic and socio-cultural factors in the current case study area. This has had a tremendous impact on the traditional knowledge of indigenous-based health treatment (Fratkin 1996).

Despite the importance of TMK for both rural and urban populations, few geographers have investigated its practices in their socio-spatial dimensions. However, the nature of traditional healing, its pragmatic and spiritual basis, and conditions for its co-existence with modern medicine in developing countries has gained recognition in research (e.g. Beck 1981). Research on TMK has examined the medicinal properties of different plant species while the social, economic and locational aspects of TMK have received less attention. While thousands of species have been documented in indigenous health systems by ethno-botanical,
anthropological and zoological researchers, fewer researchers have examined the contemporary uses and availability of these wild resources; the quantities and ways in which they are used, who the users are, how knowledge about them is transferred, and what the threats are to the species and habitats in which they occur. This study intends to contribute to a deeper understanding of the learning practices, uses and management of TMK, in relation to societal processes such as urbanization, commercialization and habitat degradation. Like many other parts of Sub-Saharan Africa, the Eastern Lake Victoria Region is going through socio-spatial transformation, reflected in increased urbanization and commercialization with linkages to global processes.

The 1978 Alma-Ata Declaration entailed the first recognition by the international community, through the World Health Organization (WHO), of the role of TMK and its practitioners in primary health care and in achieving health for all (WHO 2002). It mandated the training of health workers, including traditional medical practitioners, to a level of technical competence so as to enable them to respond to the primary health care needs of their communities (Oguamanam 2006, Cunningham 1997). WHO recognizes that, for a number of reasons, TMK and practices are indispensable to indigenous and local communities (WHO 2002). The vital and proactive contributions of TMK to primary health care are evidenced by 70-80% of Africa’s population relying on this resource base (Cunningham 2008). Swantz’s (1991) extensive scholarship in Tanzania finds a good deal of evidence of the role the TH plays today, even in close proximity to modern urban hospitals and professional practitioners of scientific medicine. The International Development Research Centre (IDRC) in Canada estimates that the services of THs within primary health care are routinely used by as many as 85% of Africans in Sub-Saharan Africa (Stanley 2004). The sectoral analysis on the market for medicinal plants in the Kwa Zulu Natal province indicates that in Africa, the market for medicinal plants lies mainly with the indigenous cultures, where traditional medicines remain an important health service (INR 2003). Widespread scholarship shows that Western medicine is both expensive and inaccessible for many indigenous and local communities (Staugaard 1985, Sugishita 2009).
The importance of TMK is also reflected in its maintained popularity for historic and cultural reasons. It is a product of social institutions and cultural traditions that have evolved over many centuries to enhance health (TMEE 2009). China is the largest global consumer/exporter of traditional medicinal products and it is acknowledged that “Traditional Chinese medicine is a treasure and embodies the unique philosophy and culture of Chinese”4. The above discussion is further clarified through statistical evidence exploring the ratios of traditional medical practitioners to the populations in Tanzania, Uganda and Zambia, which range from 1:200 to 1:400, while the ratio of Western biomedical practitioners to the population in general in these countries is 1:20,000 (Oguamanam 2006). In Sub-Saharan Africa in general, the ratio of traditional medical practitioners to biomedical practitioners is in excess of 100:1 (WHO 2002). Mhame (2004) estimated 75,000 traditional health practitioners in the whole of Tanzania, of whom about 2,000 are urban-based.

The significance of TMK has received serious attention in the past two decades, as evidenced in a Global Consensus (Cunningham 1993) as well as the 1992 Earth Summit in Rio de Janeiro through the Convention on Biological Diversity (CBD). The CBD firmly acknowledged the role of indigenous knowledge in biodiversity conservation, especially under Article 8(j), thus promoting its use as a new norm in environmental management and indigenous health care (Cormier-Salem and Roussel 2002). In China, for instance, scholarship exist which states that traditional medicines have outstanding advantages; research from the Tianjin University of Traditional Chinese Medicine indicates that they cost much less than Western medicines, while they fit in with the health service in rural areas and communities (Ha 2009)5. Recent research acknowledges the value of medicinal plants as the primary form of health care for numerous populations globally, as well as their potential for commercialization and for the pharmaceutical industry.

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3 In Benin and Sudan 70% of the populations rely on TMK, while in Uganda, users of TMK make up 30% of the population. In Ghana, Mali, Nigeria and Zambia, 60% of children with fever are treated with plant herbal medicines at home (WHO 2002, Cunningham 1997).

4 www.chinaview.cn accessed 2009-05-07

5 See www.chinaview.cn
More than two-thirds of the world’s plant species are estimated to have medicinal value, while 25-50% of modern medicines are derived from plants. Some notable examples are Artemisinin and Quinine, both medicines that cure malaria (WHO 2011). Global statistics on trade by the United Nations Conference on Trade and Development database – UNCTAD COMTRADE – which contains statistics on worldwide import and export in pharmaceutical plants since 1962 indicates figures which provide some indication of the trade in natural medicinal products. Hong Kong is the largest importer of medicinal plants, with annual import figures in 2003 of 77,250 tons (USD 133.7 million). Europe imported approximately 25% (132,000 tons) of the medicinal plants traded internationally, of which 60% were estimated to originate from Africa (see INR 2003). In 1996, approximately 26,500 tons of medicinal plants were exported from Africa to Europe (INR 2003, Mander et al. 2001). This increase in volume between 1996 and 2003 further shows the increasing importance of international trade in natural medicinal plants. An approximation indicating the importance of this sector for export earnings is that in 1999 Tanzania exported medicinal products comprising 31.63% of the total government drug expenditure for that year (USD 14.5 million). In addition, the United Nations Development Programme (UNDP) estimates that medicinal plants and microbials from the South contribute at least USD 3 billion a year to the North’s pharmaceutical industry (Mashelkar 2002).

My interest in this research is partly an outcome of my previous research on gender and the environment in East Africa, which epitomizes gender roles in the use and management of the biodiversity base (Ouma 2000). Early writings (e.g. Griggs 1981) disclose that women commonly take much of the responsibility for the well-being (in which health predominates) of children and other members of their households and communities. This is the case throughout Africa, where women are the primary caretakers, holding significant responsibility for the health and well-being of their families. If affected, they are often the first to become aware of environmental damage as biodiversity resources (among which traditional medicinal resources form part) become scarce and incapable of sustaining their families’ health and well-being.
Current health challenges, including diseases such as HIV/AIDS, place a burden on the formal health sector, not least in the Lake Victoria Region. Recent research projects have therefore focused on forging synergies between the formal health sector and the traditional health care systems in order to strengthen their respective roles in health care (KEMRI, informant interview, Alekal 2005).

This study focuses on the socio-spatial, economic and institutional circumstances surrounding TMK in the Eastern Lake Victoria Region. I address how increased urbanization, commercialization and commodification in the region have influenced TMK, as well as how this knowledge is transferred. Medicinal plants are particularly important in the practices of THs and, as mentioned, also represent a primary source of products for the pharmaceutical industry (Hamilton et al. 2003). I will also consider the different roles of formal and informal actors and organizations in the field of TMK and medicinal products. Policies regarding intellectual property rights (IPR) are defined at the global, regional and national levels, focusing on the implementation of institutional legislation and programmes for the use and management of TMK. The dynamics of the institutional structures governing TMK are thus also of relevance in this study.

Anchored on the premise that indigenous societies and communities are the holders and ‘owners’ of traditional knowledge systems and specifically TMK, it is often argued that the difficult issues surrounding TMK have arisen from a lack of respect for traditional knowledge systems, including communities (Taubman 2009). Taubman (2009) argues that TMK systems are not just “facts” but also form the socio-cultural identity of the communities, and that mishandling by others could be seen as an assault on the cultural identity of a community (Taubman, 2009). As Githae discusses, “The lack of the practice of ethics and/or its absence have subjected the traditional rural holders of knowledge to epistemological disenfranchisement by the combination of colonial, neo-colonial and apartheid practices buttressed by commercial attitudes, ethos and practices of the scientific community” (in Kamau et al. 2009:93). The failure to respect ethical codes carries legal and practical implications for the custodians of TMK (ibid.).
The past few decades have witnessed the flourishing of the international debate and dialogue within not only global governance structures and national bodies of governance but also local communities with regard to IPR and access and benefit sharing (ABS) regimes, as well as the bio prospecting of traditional medicinal plants. The role of intellectual property systems in relation to traditional knowledge, and how to preserve, protect and equitably make use of this knowledge, is a contested arena and has recently received more attention in a range of international policy discussions. The acquisition of patents on traditional medicine is a key arena for the medical industry, including pharmaceutical companies and multinationals, in order to produce and market refined plant material. Country-specific examples abound, where official governmental institutional policy and legislation are proactive in addressing contemporary issues regarding access and benefit sharing over traditional knowledge systems in general, and specifically TMK. With regard to intellectual property rights, the basic issue boils down to ensuring that the originator of intellectual property is recognized and appropriately rewarded (Taubman, 2009). However, as noted in a recent UN ECOSOC report:

The international property rights regimes often fail to recognize indigenous customary law. The IP rights regime used in Western countries is emphasizing exclusivity and private ownership, ‘reducing knowledge and cultural expressions to commodities.’ This form of ownership is protected by states and promoted by the World Trade Organization (WTO) and the World Intellectual Property Organization (WIPO) (UN SWIP 2010).

IPW (2010) has furthermore highlighted the contradictions that may exist between indigenous knowledge systems and IPR right regimes regarding the creation, ownership and transfer of knowledge:

The intellectual property rights regime and the worldview it is based on stand in stark contrast to indigenous worldviews, whereby knowledge is created and owned collectively, and the responsibility for the use and transfer of the knowledge is guided by traditional laws and customs. Indigenous traditional knowledge is also usually held by the owners and their descendants in perpetuity, rather than for a limited period (IPW, 2010).

Nevertheless, a series of international agreements and protocols on intellectual property rights have been signed and adopted globally, as well as on the
continental level. The recent Nagoya Protocol\textsuperscript{6} and the adoption of an international regime on access and benefits sharing marked a milestone agreement and the latest in a series of global meetings in the past decade. The African Regional Intellectual Property Rights Organization (AIPRO) signed a Protocol on the Protection of Traditional Knowledge and Expressions of Folklore\textsuperscript{7}, though critics warn against the application of Western legal and economic principles to collectively owned knowledge in traditional communities. The challenge is to translate such a protocol and principles to actual national legislation applicable to communities in their recognition as knowledge holders and strive for them to obtain equitable benefit sharing. Different informal and formal actors and organizations are involved in defining aspects of the ‘ownership’ of TMK, including governments and pharmaceutical companies. In this thesis I will analyse the ways in which this has implications for the practitioners of TMK, i.e. the THs themselves. I will also provide different examples of how national legislation and policy strive to address issues pertaining to the ownership of TMK.

1.2 Aim and research questions

In this thesis I analyse TMK in relation to socio-spatial transformations in the Eastern Lake Victoria Region, based on qualitative interviews with THs and key informants within different organizations in Kenya and Tanzania. The aim of the research is to examine how THs perceive ongoing societal transformations and how these processes affect their medicinal healing practices in time and space. One major aspect is how they perceive the conditions for passing on their medicinal knowledge to younger generations.

The specific research questions are:

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\textsuperscript{6}The Nagoya Protocol of 2010 is the latest in a series of international meetings adopting an international regime on access and benefit sharing.

\textsuperscript{7}The draft protocol includes sections on: 1) Assignment and licensing; 2) Equitable benefit sharing; and 3) The recognition of knowledge holders. It specifies that “any person using traditional knowledge beyond its traditional context shall acknowledge its holders, indicate its source and, where possible, its origin, and use such knowledge in a manner that respects the cultural values of its holders.”
1. Which are the historical and contemporary actors and organizational structures (formal and informal) related to the practices of TMK, and how are they viewed by THs?

2. What are the perceptions of THs regarding the status of TMK and the conditions for sustaining their knowledge and passing it on to younger generations?

3. How are processes of commodification and commercialization of TMK and products perceived by THs of different genders and ages?

Research on TMK is extensive, but rather few studies have been written about THs’ own perceptions about TMK and practices in relation to changing societal dynamics (see Vermeylen 2008). Even some of the most recent literature about traditional knowledge and intellectual property rights has paid little or no attention to the variety of ideas and perceptions that can be encountered on the ground, i.e. studies focusing on the grassroots level and the perceptions of the THs themselves (see e.g. Gibson, 2005).

Socio-spatial transformation includes contemporary processes of urbanization, migration, commercialization and commodification of TMK, as well as changing dynamics of learning and knowledge systems between generations. To obtain and source information from THs can be a challenge, since the information and knowledge about their profession and how it relates to the wider community is almost exclusively oral. This knowledge has remained largely unwritten through generations, being closely guarded and often shared primarily only with selected individuals. Ethical issues are important to consider, and specific caution has to be applied in the fieldwork and in interviews with THs and other respondents, given the historical legacies and contemporary challenges related to this knowledge system.

1.3 Disposition of the thesis

In this introductory Chapter 1, I present an introduction to the research problem and outline the aim and research questions of the thesis. In Chapter 2 I present theoretical perspectives that are relevant to my research problem and
questions. The chapter provides a conceptual discussion on TMK and discusses theories on globalization, commodification, commercialization and intergenerational learning as well as actors, organizational structures and gender. In Chapter 3, I present previous research in the different fields related to my thesis. In Chapter 4, I describe the methodology, outlining how the study builds on fieldwork in Tanzania and Kenya, where I have conducted in-depth interviews, focus group discussions (FGDs) and participant observations. I present how I employed thematic and narrative approaches as strategies for analysing my empirical materials. Chapter 5 contains a contextualization of my research in the study areas, i.e. Mwanza Region in Tanzania and Nyanza Region in Kenya, with particular focus on the historical emergence of formal and informal actors and organizations within the health care (and a short discussion on education) sectors in the two countries. This historical background is needed in order to understand how the present situation of TMK in the study areas has evolved. Chapter 6 discusses a review on health and TMK in Tanzania and Kenya. In Chapter 7, I analyse contemporary informal and formal actors and organisations within the contested arena of TMK. In Chapter 8, I analyse the challenges and opportunities of intergenerational learning processes and practices based on interviews with THs. In Chapter 9, I examine THs’ perceptions on commercialization and commodification of TMK and explore how they navigate their profession in the light of on-going socio-spatial transformation. In Chapter 10, I discuss my major findings and conclusions.
2. Theoretical perspectives

This thesis analyses TMK and socio-spatial transformation in the Eastern Lake Victoria Region, based on qualitative interviews with THs and key informants within different organizations in Kenya and Tanzania. The theoretical perspectives relevant in the thesis use both macro and micro approaches to processes that are evolving and transforming TMK and related practices. This chapter will present the major concepts and theoretical influences of the thesis. I start with a discussion on conceptual and definitional issues in which I outline my understanding of TMK, in light of a broader debate on indigenous knowledge systems versus Western knowledge systems. Following the conceptual discussion, I discuss theories regarding societal processes that affect TMK, beginning with theories on globalization. I take my point of departure in the broader context of neoliberal globalization before I proceed to theories on the more specific processes I examine in the thesis: commodification, commercialization, urbanization and changes in intergenerational systems of learning and knowledge diffusion. I also discuss gender as an important concept. The broader societal processes, which I also term socio-spatial transformations, have consequences on TMK and practices, and my empirical material indicates how THs perceive these processes: how the processes affect their practices, the ways they transfer their knowledge to the next generations, and how they understand the conditions for these learning practices. My concern is to examine the ways in which TMK and practices are challenged, transformed, reproduced and/or undermined under contemporary socio-spatial transformations. My focus, as mentioned, is on the perceptions of healers concerning these issues, expressed through their narratives in the interviews.

2.1 Traditional medicinal knowledge – a definitional and conceptual discussion

Traditional medicinal knowledge (TMK) can be understood as systematically embedded within wider indigenous knowledge systems, which have spatial, temporal and place-specific dimensions. Following Battiste and Henderson
(2000), indigenous knowledge (which I use interchangeably with traditional knowledge) can be defined as a complete knowledge system with its own epistemology, philosophy and scientific and logical validity. Grenier (1998) similarly sees indigenous knowledge systems as “the sum total of the knowledge and skills which people in a particular geographic area possess and which enables them to get the most out of their natural environment” (Grenier 1998:1). This definition resonates with others who stress indigenous knowledge as local or traditional knowledge, unique to places and societies, and often difficult to systemize as it is embedded in community practices, institutions, relationships and rituals (Tanzania Gateway 2010).

The literature further describes indigenous knowledge systems as based on reciprocity and mutual relationships between humans and nature, within a holistic worldview. It refers to the indigenous knowledge systems as embedded within communities characterized by complex kinship systems of relationships among people, animals, the earth, the cosmos etc, from which knowing originates (Ermine 1995: 101-112). It further refers to indigenous knowledge systems as the combination of knowledge systems encompassing technology, social, economic and philosophical learning, or educational, legal and governance systems (Swantz 1991, Polanyi 1966, Oguamanam 2006, Mgbeoji 2001, Odora Hoppers 2002). Oguamanam (2006) argues that:

(T)raditional medicinal knowledge systems which are embedded in traditional knowledge systems are founded on a sociocultural milieu that sustains a belief in complex spiritual and social relations among all life forms. Relations are based on reciprocity and obligations toward both community and other life forms and communal resource-management institutions which are based on shared knowledge and meaning. Western health systems embedded in Western Science is formally institutionalized, hierarchically organized, and vertically compartmentalized. The result is that the environment is fragmented into discrete components and separately managed (Oguamanam 2006:17).

The citation above illustrates what is often presented as contrasts between indigenous and Western knowledge systems; for instance, the role of Western medicine is seen as having a more rational, technical and analytical approach while traditional medicine takes a holistic approach anchored in specific socio-spatial contexts (Cunningham 1993). The wealth of theoretical writings, which
embody the nature of traditional knowledge and Western scientific systems, is arguably decisive in defining some comparative features between TMK and Western health systems. Oguamanam (2006) presents research that analyses the differential epistemic and paradigmatic view on plant life between the Western and non-Western systems and which shows that, for instance, conceptions of plant life forms in the West emphasize their economic utility, which alone does not capture the significance of plants in non-Western cultures. The argument is that among non-Western cultures (African, Oriental, Australasian and indigenous North and South American) the ideology of nature portraits an organic entity and humanity as part of an integral whole, a theory of life “whereby unity in the diversity of life forms a synthesis of materialism and deep spiritualism” (Oguamanam 2006:53, with reference to Mgbeoji 2001 and Krishan 1995). As I will discuss below in relation to commodification, this paradigm, or worldview, fits ill with a view in which plants or plant life are seen as legitimate subjects of private ownership and control, as described by the authors above. Ownership rights over intellectual property, as I will later discuss, are often referred to as intellectual property rights (IPR), which are exclusive rights granted by the relevant state authority for a given period of time for products of intellectual effort and ingenuity (Mshana 2002).

Western medicine or biomedicine is thus often contrasted with the approach taken by traditional medicine practitioners. The former is usually associated with diseases of mainly the physical body, and is based on the principles of science, technology, knowledge and clinical analysis developed in North America and Western Europe. Many aspects of indigenous or traditional knowledge, however, can be either contrasted with or, as we will see, integrated with cosmopolitan knowledge anchored in Western cosmology, scientific discoveries, economic preference and philosophies (see also Battiste and Henderson 2000). Banuri and Apfell-Marglin (1993, cited in Agrawal 1995) present a comprehensive discussion on the interaction and distinction between indigenous and Western knowledge. Using a ‘systems knowledge’ framework they find the distinguishing characteristics of indigenous knowledge (which they call traditional knowledge) to be situated in the fact that it 1) is embedded in a particular community; 2) is contextually bound; 3) does not believe in individualist values; 4) does not create
a subject/object dichotomy; and 5) requires a commitment to the local context, unlike Western knowledge, which values mobility and weakens local roots. These scholars therefore presumably distinguish indigenous from Western knowledge by considering three chief dimensions: 1) the existence of substantive differences in the subject matter and characteristics of indigenous vs. Western knowledge; 2) methodological and epistemological - these two forms of knowledge employ different methods of reality, and possess different worldviews; and 3) contextual - traditional and Western knowledge differ because traditional knowledge is more deeply rooted in its context.

The view of Agrawal (1995), however, is that no simple or universal criterion can be deployed to isolate the two knowledge systems. She argues that farmers and other local groups largely experiment and innovate by combining indigenous and Western knowledge. In her view there is need for new research to facilitate new approaches to indigenous knowledge, as many studies suffer from the commitment to the indigenous/Western science divide, and few study experimentation in rural settings over any length of time. Nevertheless, there is new research that could form the beginnings of an approach focused on indigenous practice (Fatinowna et al. 2002, Eyssartier et al. 2008, Battiste et al. 2000, Agrawal 1995). Similarly, Oguamanam (2006) states that separating the Western scientific knowledge systems and traditional knowledge on the “basis of method, epistemology, context-dependence or content is intellectually unproductive and less persuasive”. Today, what seems to be entrenched in the approaches is an epistemic and ideological conflict, which is seen as inherent in Western science/biomedicine and traditional knowledge systems (Oguamanam 2006).

This epistemic divide is also mirrored in WHO’s view of health, which incorporates two epistemic responses to ill health, namely the Western scientific and the traditional or non-Western systems. Importantly, though, WHO does not present these as being in conflict with each other. In essence, its mandate defines health as a state of complete physical, mental and social well-being and not merely the absence of disease. It can therefore be argued that this defines a pluralistic theory of health, which accommodates the biomedical and psychosocial paradigms associated with the Western and non-Western/tradition-
nal approaches to health and disease. According to Bode (2006), medicine — apart from offering strategies for dealing with non-well-being in a somatic, psychological and social sense — represents cultural ideas about health, illness and therapy. WHO’s pluralistic theory and view of health mandates the organisation to provide a treaty/regime that can empower and regulate TMK, from its currently subordinated position (see also Odora Hoppers 2002). Oguamanam (2006) asserts that despite the high-level mandate by WHO with regard to global health policy, a guiding or regulatory convention on TMK is nevertheless absent (ibid: 95).

A related concept in this discussion is tacit knowledge, and in the context of its role in understanding knowledge as a whole, and specifically traditional knowledge, it features in philosophical ideas developed by scholars like Michael Polanyi and Amartya Sen. Sen discusses these ideas, offering a view that “giving knowledge such a central position in the knowledge of the world, presents one to draw on a deep rooted understanding of how knowledge emerges and flourishes in the world of nature especially in the world of human beings and human minds within that larger whole” (Sen as cited in Polanyi 2009:2). Polanyi’s argument is that we can know more than we can tell, and that tacit knowledge that “cannot be easily formalised and put into exact words, has a sweeping presence in the world while being a central feature of our knowledge of that world” (Polanyi 2009:2). The argument is that if tacit knowledge is a central part of knowledge in general then we can both 1) know what to look for and 2) have some idea about what else we may want to know. An implication drawn from this perspective, according to Polanyi, is therefore that “the process of formalizing all knowledge to the exclusion of any tacit knowledge is self-defeating” (ibid: 2). Drawing from this, both TMK and Western knowledge can be understood as having a knowledge base of which a broad and important part has yet to enter the formalized realm, and which is characterized by heavy reliance on tacit knowledge.

Scholars such as Odora Hoppers (2002) and Oguamanam (2006) argue that the often contrasted and negative perceptions of THs and traditional medicine reflect an ethnocentric divide between the two worldviews, the Western and non-Western. The disdain for traditional therapeutic methods and their custodians
reflects the hierarchical and paradigmatic divide between Western biomedicine and traditional therapeutic activities (Oguamanamn 2006). With an example from Australia, Cotton (1998) states that the “medico-pharmaceutical apparatus has proved enormously proficient in maintaining hegemony over Australian Aboriginal health systems with the current dominant service delivery mode being the BIO psychosocial model” (Cotton 1998:32). Odora Hoppers (2002) suggests that this emanates from a general trend whereby the exclusivity of Western knowledge systems with its accompanying rational and linear framework has in practice meant that cosmological approaches not fitting into this framework have been dismissed and ridiculed.

Fabrega (1990) discusses how the defining approach to illness within TMK, as a social and not just a personal concern, is regarded as the most fundamental difference between Western medical systems and traditional medical systems. However, the formal medical systems also include specific theories on health and healing, many of which emphasize the value of maintaining balance between the physical, mental and emotional aspects of life. Although the value of a holistic approach is acknowledged, treatments nevertheless tend to be disease- rather than patient-centred and less tailored to the particular needs of the individual than in other medical traditions (Fabrega 1990, Grol et al 1990). Another important aspect of TMK is the status of the medicinal practitioner, whose diverse role as healer of illnesses as well as community leader is discussed by Staugaard (1985) and Sugishita (2009). The role of THs or traditional medicine practitioners as actors and members of specific communities should be viewed within a holistic perspective. In such a perspective, health and well-being are placed in a context where good health, success or misfortune and disease are perceived not as occurrences through fate, but rather as things that occur due to the actions of individuals and ancestors causing balance or imbalance between the individual and the socio-spatial environment.

While many argue that there is no definition that fully engulfs or captures traditional or indigenous knowledge, some scholars also note that, partly for ideological reasons, there exists a characteristic reluctance - especially among indigenous scholars - to define traditional or indigenous knowledge (Oguamanam
One point of consensus, however, is that indigenous peoples’ knowledge and worldview are based on holistic conceptions of phenomena in an entangled web of relationships, comprising a complex set of technologies developed and sustained by indigenous civilizations, whose approach has an interdisciplinary source of knowledge. According to Battiste (2002), indigenous knowledge systems embrace the contexts of about 20% of the world’s population and draw on a conceptual definition as “knowledge which comprises the complex set of technologies developed and sustained by indigenous civilizations; often oral and symbolic, while transmitted, through the structure of indigenous languages and passed on to the next generation through modelling, practice and animation, rather than through the written word” (Battiste 2002:2).

Chambers (1983) further broadens the concept of indigenous knowledge as “the whole system of knowledge including concepts, beliefs, perceptions, the stock of knowledge and the process whereby it is acquired, augmented, stored and transmitted” (Chambers 1983:83). Its non-static and place-based nature is further defined and explored through scholarship indicating its development over generations of search and interchange between groups. Indigenous knowledge can be situated within a consistent and coherent set of cognitions and techniques that have evolved through the trial and error of generations of societies who have had to live by the results. The close interaction between mankind and environment provides a system that may evolve as unique to specific societies (Chambers 1983, Titilola 1991, Richards 1985, Warren et al. 1989). Niamir (1990) further describes the dynamic nature of indigenous knowledge as ever-changing and as often selectively borrowing from outsiders (see also Rutatora 1994). In this view, indigenous knowledge is understood as localized knowledge unique to particular societies, whether characteristically rural, urban, settled or nomadic, practiced by original inhabitants or migrants. In the empirical chapters I will further explore how different actors perceive the relationship between traditional and Western knowledge systems as conflictive or non-conflictive.

Drawing on many of the arguments above, in this study I follow not only WHO’s but also Hirt and M’Pia’s (2008) and Geissler et al.’s (2002) definition of TMK as the sum total of health knowledge of innovations, practices, methods, treatments,
supplementary materials and attempts of any kind (tangible and non-tangible) which for generations have enabled societies to protect themselves from sickness, relieve suffering and bring about healing. TMK is adapted to local socio-cultural, socio-economic and environmental contexts, and is predominantly transferred orally from generation to generation. Similar to other forms of traditional knowledge, it is mainly of a practical nature. TMK tends to be collectively owned, and is embedded in socio-cultural values and belief systems, rituals, community laws, local language and environmental practices. I further understand TMK and Western medicinal knowledge as non-static and dynamic systems of knowledge. Likewise, following WHO and researchers like Langwick (2011), Last et al. (1988), Mokaila (2001) and Staugaard (1985), I embrace a pluralistic theory of health, in which it is possible to accommodate both Western medicinal knowledge and traditional health knowledge rather than seeing them as antagonistic.

2.2 Theories on globalization

As discussed earlier, TMK is affected by broader economic, political and socio-cultural processes, which in contemporary times often come under the label of ‘globalization’. The importance of the concept of globalization to geographers lies in how it exemplifies and emphasizes social, economic, cultural and environmental relationships and interactions across the globe (Walby 2009). The meaning of globalization is not entirely clear, with substantial disagreement and contested views abounding among both academics and those who use it daily to define or describe a myriad different events and development trends (Jensen & Tollefsen 2012). Being the subject of charged public and academic debate (McGrew 2000), globalization is never neutral or value-free, and is perhaps one of the most discussed terms within the social sciences (Jensen & Tollefsen 2012). Globalization processes, though valued differently by different actors and groups, are often presented in general terms involving aspects such as: economics, competition, financial transfers, capital investments, trade, economic growth or crisis, as well as political, cultural, social and environmental dimensions. Despite sweeping references to the decline of the nation state, culture, tourism, fashion and environmental problems, the “economic context and related vocabulary is
Globalization, in a contemporary context of predominantly neoliberal policy influences, is argued to have reinforced the weight of market forces, while eradicating the constraint of geography through technological advances in communication and transportation.

Mackinnon et al. (2007) describe the role of transnational corporate interchanges and networks that have bypassed the nation state, which in turn is not able to regulate or control market forces. Globalization is argued to be driven by a confluence of forces such as economic, technological, political and cultural shifts (McGrew 2000). Castells (1996) posits globalization as embedded in numerous transformational dimensions within the social landscape of human life, the most significant of which are global economic interdependencies, technological revolutions through information technology, and new relationships between economy, state and civil society.

Scholarship discusses three different positions on globalization: whether it entails the entrance into an entirely new epoch for all to adjust to; whether it is but a
historical continuum that dates back several hundred years; or whether it is a recent phase in capitalism in which Transnational Corporations (TNC’s) international work divisions are central but which is generally better analysed with more precise theoretical tools than the ‘globalization’ concept (Jensen & Tollefsen 2012).

I understand TMK and related practices as affected by uneven geographical development and commodification in a context of neoliberal globalizing processes. Recent globalizing processes – such as the deregulation, increased commodification and commercialization of more and more spheres of human life – have gained influence; however, these processes are spatialized, partial, uneven and perceived differently by different actors. These broader global economic restructuring processes are important to identify as they are related to the increasing commodification of traditional medicine in the research context – leading to the questions dealt with in this thesis concerning the extent to which these processes may potentially change the practices themselves (including intergenerational learning processes) in order to fit market demands.

Globalization is thus a contested term, regarding whether it portrays a *nouveau* stage in capitalism or simply a continued race of global processes that have defined capitalism since its *infancy* in the 15th century (Acker 2004). Other views include globalizing processes having emerged much earlier, not tied to capitalism (Sen 2002). Other arguments contend whether socioeconomic and socio-cultural processes have fundamentally transformed, improved or undermined conditions of daily lives, reflecting over how these forces have circumvented the autonomous nature of nation states (Acker 2004). Assuming that capitalism has always been global in nature, what is characteristic is that certain changes can be discerned in the past three decades or so, with an accelerated velocity of diverse cross-boundary penetrations of capital, production and people (Acker 2004).

Gibson-Graham (2006) links globalization to capitalism, illustrating capitalism as “not a complete economic system by itself, but rather, a part of the global economy, in which other modes of production function. It is the global market economy which shapes, and is equally shaped by, diverse local economic realities”
(Gibson-Graham 2006:25). Neoliberal globalizing processes and changing patterns of production and consumption are portrayed in how discourses of globalization are disabling, as expressed by Hart (2002). While the term globalization is contested, a consensus emanates from an understanding that it is central in terms of intensified processes in time and space and the resulting interconnections and entrenched capitalistic restructuring. Of significance are the growing forms of globalization that circumvent the historic cores of capitalism (ibid.). Globalization - it is claimed - captures a multiplicity of changes that are altering the contours of economies, polities, and social life in general at the end of the 20th century and the beginning of the 21st century (Acker 2004). In concrete terms, it is implied that:

The proliferation of processes including organizational restructuring, downsizing, new forms of flexibility and new forms of employment relations are parts of free marketization described in scholarship as ‘the new economy’; all of which are inter related and are shaped by the common ideological dominance of neoliberal thought (Acker 2004:2-3)

Gibson-Graham (2006) discloses the role of capitalism in the marginalization of indigenous populations and the perception of these populations as a resource subject for the benefit of major economic actors in the globalization project. It can be stated here that on the economic facet, globalization has continued to propagate capitalism as a new force of global economic life. While the notorious ‘poor-rich divide’ has ascended from national boundaries to the global level, its promoter considered to be key international financial institutions, the transnational flow of investment by multinational companies with free trade options has guaranteed the accumulation of wealth in a few hands and the prevention of global trickle-down effects. In their discussion on north-south dimensions in the globalization debates, Jensen and Tollefsen (2012) argue that this divide is often “strangely invisible” in the debates, despite rhetoric on the importance of the global perspective. Connell’s (2007) argument is cited, in which dominant social scientific theories on globalization in themselves are weak foundations and mirror historical power relations and the metropole’s view on the periphery. The earlier experiences of globalization, i.e. colonialism and imperialism, are “silent” in the dominant contemporary theories on globalization;
phenomena that are theorized from the metropole’s perspective (Connell 2007 in Jensen & Tollefsen 2012).

Hoogvelt’s (1997) argument on globalization defines the structure of domination as altered towards new social divisions around four concentric circles cutting across societies and regions: the world “elites, the affluent middle class, the marginalized and the dispossessed”. The term globalization is problematized by Santos (2002), who discusses some forms of globalization as hegemonic and unequal to dominant forms of knowledge and economic development, for instance in terms of biodiversity exploitation, homogenized food systems and educational systems. Santos defines counter-hegemonic globalization processes as networks and inter-exchanges at local levels against marginalization and social exclusion. The consequences of globalization are a subject of debate and dispute.

Gibson-Graham (2006) further examines how populations develop their own ways of coping with, confronting and potentially resisting capitalism in their own territories. The scholarship offers existing alternatives to a global capitalist order and outlines strategies for building alternative economies in place and over space. Gibson-Graham ‘merges’ political economy, feminist post-structuralism and economic activism to design ethical considerations in constructing economic development approaches. Cloke et al. (2005) also discuss ethical considerations related to globalization in their scholarship on moral economies. They discuss the “moral turn” in geography, which in addition to emphasizing the ethical dimensions of geographic research has enquired into the “social justice of geographical differences and the moral construction of communities without proximity” (Cloke et al. 2005:28). This is in relation to the spatial ethics of consumption and the geographical lengthening of the food chain.

2.2.1 Gendering discourses of globalization

According to Nagar et al. (2002), theories on economic globalization and feminist understandings of global processes have largely remained separate. However, there is a broad scholarship examining the ‘double marginalization’ of subjects
and spaces that is characteristic of dominate accounts of globalization. This scholarship argues that:

Women are sidelined, as is gender analysis more broadly, and southern countries are positioned as the feminized other to advanced economies (Nagar et al. 2002:266).

There are compelling feminist accounts of the entanglement of gender in the global economy and within developmental contexts (Nagar et al. 2002, Roberts 2004, Gibson-Graham 2006). These have challenged the “masculinist hyper-mobility” that Pratt et al. (2003) consider characterizes numerous academic discussions of globalization. Empirical evidence abounds that highlights the experiences of women and marginalized societies of neoliberal processes and reconfigurations of national economies, including coping strategies they have adopted to cope with these changes (Cupples 2005, Davies et al. 2005, Acker 2004). Acker argues that gendering the discourse of globalization can help to develop a better understanding of globalization processes and their consequences for both women and men.

Gender structures affect the economic, political and social opportunities and constraints of both men and women. The evolving global processes mentioned earlier influence the way men and women relate to economic challenges. Feminist analyses of gender and globalization discuss gender as socially produced and highly variable, while recognizing the predominant subordination of women within gender relations. Acker (2004) argues that the structural and ideological division between production and reproduction was shaped along lines of gender and has contributed to continuing gendered inequalities. This paradigm predominates in the organization of productive life, where a general contradiction between production and reproduction contributes to gendered globalizing processes, frequently within corporate practices where there is only ‘rudimentary’ responsibility for reproduction of human life and reproduction of the natural environment.

The discussion by feminist scholars revolves around the gendered organization of social life, which helps and perpetuates the reproduction of different and unequal
lives for women and men, which at the same time is not similar or consistent consequential for all segments of the population. Thus, class, race and ethnicity are important aspects that reinforce inequalities, in a time of globalizing processes with inequalities being reinforced and poverty levels in Eastern and Southern Africa in many cases increasing. It is during these times and under these conditions that women’s unpaid labour keeps life going. In this study, I consider gender as one important dimension of how TMK is passed on from older to younger generations in different places, for instance in terms of whom can be taught and who can do the teaching, which in turn is influenced by gender norms and gendered patterns of migration and labour markets.

The process of globalization thus generally defines increased and intensified global interdependencies and interconnectedness in flows of capital and commodities: movements and displacements of populations. Within this broader context of neoliberal globalization processes, in this thesis I will more specifically examine processes such as commodification, commercialization, increased migration and urbanization, changes in intergenerational learning processes, policy debates and dialogue, and their consequences on TMK and practices.

2.3 The concepts of commodification and commercialization

Commodification, according to Nitcher (1996: 269), is a term used in various ways within the social sciences. Though commodification and commercialization are closely related terms and processes, some difficulty is involved in distinguishing them (Jacob 2003). In this study I will discuss both the emerging commodification of TMK and the commercialization of traditional medicinal products and practices. While commercialization is viewed as encompassing the monetary processes surrounding commodified knowledge, Jacob (2003) defines the commodification of knowledge as:

(T)he process by which knowledge is reduced to a format that makes it possible to make an exclusive package or artefact for which an exchange value may be established. The process of commodification presupposes or is dependent on commercialization (…) A definition of commodification entails the transformation of relationships, formerly untainted by commerce, into commercial relationships, relationships of buying and selling (Jacob 2003:127-128).
Commodified knowledge is thus a product which is extracted and packaged and can be exchanged (bought and sold) for a monetary or tangible exchange value attached to it. The individual actor involved in the selling is enabled to claim ownership or propriety of the product, which also is a central characteristic of contemporary forms of intellectual property right regimes. Regarding commodification of knowledge, Jacob (2003) argues that academia is both a promoter and a “victim” of knowledge commodification. At universities all over the world, the issue of commodification revolves around property rights in the form of patents and licences, which helps promote both the commodification as well as the commercialization of university-based knowledge production.

According to Appadurai (1986), commodities could be said to have social lives because they embody value as created by a society. The “commodity phase” represents the moment during which an object is operating as a commodity with value. Using the theory of the social life of things, Appadurai (1986) suggests that commodity is only one phase in the social life of an object; as it travels within different regimes of value, it may exit and re-enter the commodity sphere. Commodities and their commodification processes therefore relate complex, context-specific messages within a culturally constructed framework. Theories on commodification often draw on Marx’s work (Lapavitsas 2004), which assigns the term commodification to objects with attached economic or commercial value they did not previously possess; it presents them as commodified if they are produced for the market rather than for personal use. The producer/owner and the consumer enter a relationship in which commodities are traded or exchanged, thus initiating commerce in the commodity.

Ertman et al. (2005) present groundwork for a critique of commodification, discussing its role in reducing all human interactions to economic transactions. However, commodification can have diverse meanings in different social contexts, and recent debates have moved beyond the pros and cons of commodification while instead assessing the quality of the social relationships and wider context involved in the transaction (Ertman et al. 2005). Feminist research has identified the division between commodity production in the capitalist economy and the reproduction of human beings and their ability to
work as fundamental in women’s subordination in capitalist societies (Mies 1986 in Acker 2004). Within a context of neoliberalism, there is legitimacy for some parts of reproductive services (including health care) to move into the capitalist economy and become available only to those able to pay (Acker 2004).

2.3.1 The gift economy

Commodification and commercialization are ongoing processes that can be contrasted with the logics of the gift economy. The gift economy is commonly associated with exchanges within indigenous knowledge systems, but also with other contemporary societies. THs working with TMK have been found to engage in arrangements defined by Swantz et al. (1996) and Polanyi (1966) as a profession defined in terms of a gift. According to Swantz et al. (1996), much of the informal economy in Tanzania operates along these lines whereby Kipaji	extsuperscript{8}, received as a gift, engages THs in a gift economy in which reciprocity and mutuality are paramount. Geissler et al. (2002) denote how intergenerational learning and transmission of TMK in Luo society engage the reciprocity dimension that defines a gift economy. As I will discuss in the empirical section in relation to commodification and intergenerational learning, aspects of TMK as a profession will be viewed in relation to a gift economy as well as dynamic ongoing processes. By identifying a complex web of exchange and obligations involved in the act of giving, Mauss’ (1970) work on the gift economy of the 1920s revolutionized our understanding of many of our social conventions and economic systems. While exploring gift exchanges in various cultures, highlighting the reciprocal nature of gifts and the obligation of the receiver to repay the debt, he viewed exchange and reciprocation as the basis of human society. He also argued that gift exchanges still define, and are applicable to, contemporary societies. A similar discussion is found in Karl Polanyi’s work on “human ecology”, in which reciprocity and mutuality are paramount. Elson (1994) emphasizes the interdependence of monetary and non-monetary economies, although she recognizes that macro-economic policy considers only the monetary economy, ignoring the non-monetary one.

\textsuperscript{8} literally meaning ‘brilliant’
Swantz et al. (1996) further define the gift economy as the “economy of affection”. They argue that investing in the ‘economy of affection’ serves a dual purpose: it gives value to the most important human relations, and establishes wealth as constituting not only the financial status one achieves but also the wealth one wields in accessing people themselves. At the same time, it helps create a web of ties that can be drawn on to facilitate one’s endeavours and may serve as a safety valve. Investing in one’s ties of affection and engaging the market, however, are not mutually exclusive objectives, as Hydén 2004 suggests, but rather can be mutually reinforcing aspects of life. Reducing individuals simply to economic actors misses the mark and does not appreciate the many ways in which humanness is expressed (Swanz et al. 1996).

2.4 Urbanization, the youth and changing patterns of production and consumption

Traditional medicinal knowledge is examined here within the broader neoliberal globalization processes, with specific reference to increased migration of predominantly youthful populations, the allied urbanization patterns, and how these transform or influence livelihood patterns and strategies. Theoretical approaches attempt to disclose how these processes engage with TMK and related consequences on TMK and practices, as I later discuss and analyse in the empirical sections in relation to THs’ perspectives and views on these processes.

Harvey (1989) presents time-space compression as a concept related to globalization processes. It captures the increased velocity of economic life and the increased movement of information and capital. Time-space compression is further exemplified by the ‘demise’ of barriers and the intensification of interrelationships between rural and urban spaces, as well as an increased mobility of people. Urbanization is a phenomenon that brings geographically separated groups into contact with each other in new social, economic and cultural settings. Social networks provide a mechanism for migration, the diffusion of new ideas and innovative behaviours, and the enforcement of group norms, and enable learning and influences to occur through social interaction (Lindstrom and Munoz Franco 2005). While the causes and effects of
urbanization are complex, it could result in migrants bringing knowledge and practices that are new to the area of arrival (Nesheim et al. 2006).

A large percentage of rural-urban migrants are the youth. The increasing inequalities within and between urban and rural areas has given rise to what Laurenco-Lindell (2002:10) defines as “a growing number of disillusioned youth with few stakes in global capitalism making themselves heard in cities everywhere, reflecting the shared predicament in different parts of the world”. Rural-urban migrations involve social, economic and cultural transformations, including changes in health practices and knowledge. Urbanization processes alter production and consumption patterns and the attachments people have to places. Rural migrants adapt to new social, economic and natural environments (Nesheim et al. 2006), which challenges beliefs, values, knowledge, technology, exchange systems, and many other aspects of their lives, including their recognition and use of natural resources.

Bryceson (2002) underscores that the effects of economic crises and structural adjustments have rural-urban dimensions. Measures taken for economic stabilization advocated by international financial institutions take a heavy toll on the standard of living of most urban dwellers, with their effects on retrenchment and declining urban employment, rising costs of living and falling real wages (Laurenco-Lindell 2002). While globalization will increasingly shape the development and utilization of the technological path, new risks for marginalization and vulnerability will continue to emerge (Mshana 2002).

Neoliberal policies may change structures of export commodities, which have consequences on rural and urban economies, as prices for agricultural produce decline. Urban populations are increasingly diversifying in informal livelihood strategies to supplement declining wages, and in many contexts urban farming is a supplementary livelihood strategy (Swantz et al. 1996). Laurenco-Lindell (2002) terms this diversification more broadly, as the reinvention of traditional socio-cultural practices in order to deal with the challenges of contemporary urban life. She further defines it as a new wave of informalization and asserts that informality now constitutes a pervasive feature in most cities, while formal
mechanisms are reported to regulate only a small part of urban relations and dynamics.

Mwamfupe’s (1998) research shows that while rural population densities have reached critical levels, villagers are starting to experiment with various non-agricultural activities alongside their agricultural work. Examining household control over resources such as land, labour and capital, changing patterns of land and labour allocation between generations within rural households reveal the increased reluctance of the youth to engage in agricultural activities. A twin process of land shortage and the attraction of urban life seem to have prompted rural-urban migration. The lack of rural employment opportunities encourages particularly the youth to seek employment in urban areas; for them, urban areas seem to foster aspirations to establish their own businesses. Livelihood diversification, as theorized earlier, has included petty trading, with agricultural activities less attractive to the youth in terms of economic gain due to low agricultural returns in recent years (Helgesson 2006, Mwamfupe 1998).

Processes of urbanization have various impacts on rural areas. Parallel to the economic gain, men and the young migrate to towns, leaving rural areas to be managed mostly by women and the old. Urbanization can create economic opportunities for the populace, both rural and urban, while rural places often remain crucial for migrants, not only for family or livelihood reasons but also for reasons of health and well-being.

**2.5 Dynamics, challenges and changes of intergenerational learning**

While views abound which explore indigenous pedagogy and epistemology and their intergenerational dimensions, which relate to place, history, language and social relations, this study necessitates exploring scholastic views that place intergenerational learning within emerging approaches and dynamics that surround and influence the transfer of traditional knowledge and indigenous knowledge more broadly, and traditional medicinal knowledge specifically. In an era increasingly characterized by regimes of dynamic, changing societal influences including social-spatial, political and socio-economic processes, the
study views TMK intergenerational learning in relation to its placement within a contested arena, characterized by ongoing dynamic changes and contexts in place and space.

Intergenerational learning processes are viewed by some as being as old as mankind; historically they have been an informal vehicle within families for the systematic transfer of knowledge, skills, competencies, norms and values between generations (Hoff 2007). Intergenerational learning has temporal and spatial dimensions and is influenced by political, social and economic processes. Intergenerational exchanges can provide new generations with intended historical and placed-based knowledge, which is grounded in history and provides a link to the past (Hanks 2007). While theories of learning cover a variety of pedagogical models, intergenerational learning is the dominant form of learning within indigenous knowledge systems, including medicinal knowledge systems.

Socio-cultural theory attempts to conceptualize the transmission of knowledge between generations, or what Cole terms prolepsis (Cole 1996). The passing down of grandparents’ experiences to the younger generation is negotiated, while knowledge and values are re-evaluated in the context of a rapidly changing world. The older generation bring memories of past experiences into current interaction with the child/youth, with the adult expanding and limiting the child’s experiences as he/she imagines what the child’s future might be. Thus, changing cultural dynamics and contexts provide a space to examine how prolepsis functions between generations (Cole 1996).

Learning processes take place between individuals of different generations but within genealogy (vertical transmission), as is the case from parent to child (Eyssartier et al. 2008). This learning and transmission of knowledge may also occur between individuals of the same generation irrespective of their relationship (horizontal transmission). Studies on intergenerational learning between children and grandparents reveal learning interactions that are co-constructed within a relationship of mutuality, leading to the development of concepts and skills which complement school learning while invoking cultural continuity and change (Kenner et al., 2007).
2.5.1 Intergenerational learning and metropolitan theory

Connell (2007) argues that the bulk of scholarship on what knowledge and learning entail is based on metropolitan theory, whose strategy produces readings and knowledge “from the centre”. This is exemplified in the fact that the prevailing dominant scientific paradigm in school education within the periphery is in a context that permits few elements of local contextual practices to surface (IKAP 2007). Aboriginal and First Nation scholarship on learning processes cites the greatest challenge in addressing this question: to find a respectful way to compare Eurocentric and indigenous ways of knowing and to include both in a blended educational context that respects and builds on both indigenous and Eurocentric knowledge systems and systems of pedagogy (Battiste 2005). In other words, “animating the voices and experience of the cognitive ‘Other’ and integrating them into the educational process, creates a new balanced centre with a fresh vantage point from which to analyse contemporary education discourse and its pedagogies” (ibid: 5).

According to Fatnowna et al. (2002), indigenous knowledge systems and ways of learning have been not only weakened but also colonized through the interpretive “writings about”, for instance, Aboriginal peoples. The ‘Other’ was made object by non-indigenous experts (Fatnowna et al. 2002, see also Macedo 1999). Aboriginal learning systems are/have been situated as a voiceless ‘Other’, with ‘Aboriginalism’ constructed within the social and political theory of the times, which rationalized colonialism and its practices (ibid: 71). The interests in knowledge transfer and ways of knowing of Aboriginal peoples and communities have long survived on a significant battleground of epistemological resistance (Odora Hoppers 2002:6). This resistance and struggle have sometimes been driven by non-indigenous and indigenous peoples together (Fatnowna 2002). As defined by Tema (2002), learning and knowledge transfer involve the acquisition of unfamiliar knowledge, which may perhaps involve a change in one’s worldview, a process that can occur rationally. However, unless the key aim is indoctrination, the intended result of learning and the transmission of knowledge with the corresponding change of worldview will be achieved if provided with rational
approaches. A learner needs to know why he/she has to abandon his/her beliefs and adopt new ones (ibid: 132).

Another dimension in scholarship discusses the hierarchy of knowledge, which depends on the power that has been attached to different types of knowledge in society (Dahlström et al 2006). Every field of knowledge has its internal hierarchy, which goes with status. Thus, within academia, “natural sciences having a higher status than the social sciences while the latter in return have a higher status than that of knowledge that is produced in marginalized countries” (ibid: 58). Though knowledge can be seen as universal heritage, it is characterized by hierarchical relationships, which are dictated by and closely related to the power of the preferential right of interpretation over educational practice, thus the right to define what counts as appropriate knowledge about practice.

2.5.2 Oral narratives and place-based learning

In general, oral traditions are a people’s popular narratives with intimacies embedded within pedagogy. An oral culture where a variety of practices still persist includes knowledge repositories held by people whose role of transmission and learning is entwined with responsibility for its proper storage and making it available to subsequent generations. Oral narratives can shed light on people’s views on dynamic processes about societies, can embody the history, cultural values, philosophy and beliefs of a people, and can provide the youth with models to emulate while growing up according to societal expectations. They can also entail knowledge provision that teaches individuals how to be responsible for their own lives, develops their sense of relationship to others, and helps them model competent and respectful behaviour (Battiste 2002).

Intergenerational learning research and practices have temporal and place-based dimensions, whereby for instance the interaction over periods of time between adults and children reinforces knowledge transmission, beliefs and practices through either direct teaching or informal activities in homes or community settings (Gadsden et al. (1996). In further emphasizing the role of land (place and spatial dimensions) in knowledge transmission, scholars suggest that the
transmission of knowledge from generation to generation also depends on “maintaining the integrity of the land itself” (Battiste 2002: 13). Morphy further clarifies an understanding of place- and space-based indigenous knowledge learning and how it is inherently tied to the land – though not to land in general but rather to specific landscapes, landforms, and biomes where ceremonies are properly conducted, stories properly recited, medicines properly gathered and transfers of knowledge properly authenticated (Morphy 1995).

2.5.3 Reciprocal valorization and learning of knowledge

The epistemological and pedagogical nature of indigenous knowledge transmission is embodied in philosophies, theories, histories, ceremonies and stories as ways of knowing. However, its definition still portrays knowledge relating to the technological, social, institutional, scientific and developmental discourse (Odora Hoppers 2002:9). De Sousa Santos (2007) suggests that modern science teaches little about our way of being in the world, with this scantiness inscribed in the very form of knowledge it constitutes. This references a paradigm that produces “both knowledge and ignorance” (De Sousa Santos 2007:40). Similar arguments regard knowledge as becoming more synonymous with information rather than with understanding and wisdom. “We are all drowning in information while starving for wisdom”, as expressed by Wilson (1998:269 in Fatnowna: 2002). Such views seem to suggest that the crux of the pedagogical divide is that indigenous knowledge pedagogy and learning embrace both the circumstances people find themselves in (empirical) and their beliefs about these circumstances (normative) in a way that is unfamiliar to contemporary philosophical systems, which seem to clearly distinguish between the two (Battiste 2002:19).

Battiste et al. (2000) continue to argue that knowledge transfer in the context of indigenous teachings is not understood as something that some possess and others do not, and that can be controlled by educational institutions. It is rather seen as a living process to be absorbed and understood, while learning is viewed as a lifelong responsibility that people assume to understand the world around them and to animate their personal responsibilities. Indigenous pedagogy seems
to place attentive value on the individual’s ability to learn independently by observing, listening and participating with a minimum of intervention or instruction (ibid.). The intended outcome of such a learning system is a prize in the form of a well-rounded person who is people-centred (Ntuli 2002:61).

A knowledge paradigm that could claim to be a translator encourages the emigration of concepts and theories developed locally to other cognitive spheres and their utilization outside their original context (De Sousa Santos 2007:36). It could encourage educators to allow students to bring the cultural experience to the learning situation (Tema 2002). This could provide tremendous scope between formal and informal learning and knowledge systems (Gupta 1999), and for the reciprocal valorization of learning and the transmission of knowledge (Hountondji 1977). Scholarship based on southern theories acknowledges that “knowledge is a universal heritage and a universal resource while emphasizing its diversity, variation and being context specific” (Hountondji 2002). Knowledge production can be viewed as occurring in all discourses, not just transmissive, due to its essential creativity – thus returning to the view that indigenous knowledge production exhibits diverse ways of knowing, premised on the pluralism of knowledge, with no uniform approach or generic label assigned to it, while exhibiting geographical and cultural diversity within indigenous knowledge production (Battiste and Henderson, 2000). According to Fatnowna et al. (2002), knowledge systems operate within structures that reflect the ways knowledge is created, learned, maintained and re-shaped. In other words, “Indigenous Knowledge as a complete knowledge system with its own Epistemology, Philosophy and Scientific logical validity, can only be understood by means of pedagogy traditionally employed by the people themselves” (Battiste and Henderson, 2000:41).

Another view situates knowledge learning and transmission within contemporary indigenous life, and highlights how its diversity draws distinctions between, for instance, everyday knowledge and sacred knowledge, gender-restricted knowledge, and readiness for certain knowledge according to age, maturity or law (Fatnowna et al. 2002). In other words, knowledge learning and transmission are heterogeneous but with distinctive compartments that are accessed depending on
who is to be taught, at what age in one’s life course and what the subject or purpose is.

2.5.4 Break-up of intergenerational learning and forms of resistance

Majeke (2002) argues that the present system of education in Africa is practically unsuited to deal with the nature and profile of issues that originate from African communities. He asserts that syllabi emphasize the social and cultural rhythms of the colonial settler communities complete with the conceptual structures and categories of thought (Majeke 2002). Premised on learning processes which emerge from the metropole, a mainstream paradigm is safely installed as the only way of seeing and the only tool by which masses of humanity can receive knowledge, accreditation and a licence to be (Odora Hoppers 2002). A similar view is discussed in the Aboriginal discourse, where outright disdain for Aborigines’ knowledge and their associated pedagogies dominates the discourse that discusses methodologies that prevented and expected the abandonment of Aboriginal learning styles (Miller et al., 1988:25). Bourke’s (1994:135) view similarly encompasses aspects of spatial conquest and dislocation, coupled with the ‘mind’ through the incorporation of the indigenous local learning and transmission systems into Western pedagogies. Associated gaps in knowledge and cultural continuity, paved through policies of banning language and cultural practices, were framed through the forced spatial removal of children from the proximity of older generations. Miller et al. argue that forced migration created a situation in which Aboriginal inhabitants of Australia, having complex and successful ways of teaching children (and young adults) what they needed to know, were incorporated into ‘schooling’ and mainstream assimilationist prohibitive approaches that offered no place or space for their own pedagogy.

A form of resistance against the break-up of intergenerational learning is found in Canada, where indigenous knowledge pedagogies have generated a decolonizing and a rethinking of education and learning for indigenous peoples (McConaghy 2000). The emerging scenario blends indigenous knowledge pedagogies and intergenerational learning processes with contemporary educational philosophies, while the issue about whose knowledge is validated in educational
enterprises is raised (Battiste 2005:22). Dedicated attempts are made to effect ‘two-way’ approaches in educational learning processes, with an ideal curriculum defined by Harris (1990) as “a dual curriculum”.

Another form of resistance entails indigenous scholars and academics - as an act of empowerment - attempting to affirm and activate the holistic paradigm of indigenous knowledge learning and transmission to reveal the wealth and richness of indigenous languages, worldviews, teachings and experiences (Battiste 2005). Crossman et al. (2002) in turn note that plural knowledge systems and practices are undergoing a fundamental shift with an aim of mutual decolonization. They draw on knowledge learning systems from other worldviews, including the Chinese, Ayurvedic, Balinese, Japanese, Arabic and First Nations, who are forcefully affirming their specific epistemologies, cosmologies including ethical and ecological concerns.
3. Previous research

In this chapter I discuss previous research on neoliberal globalization and implications for indigenous knowledge systems in different contexts. I also discuss research on urbanization and place in relation to TMK and practices. Studies on commodification, intellectual property rights and commercialization are also considered, as well as research on intergenerational learning practices and their challenges and opportunities.

3.1 Neoliberal economic restructuring and implications for traditional medicinal knowledge

Drawing from the South African context, Hart (2002) looks at practices and processes of dramatic local economic and social restructuring. In the South African context, changes are linked to the attraction of investors under the general term ‘local economic development’ in spaces that had experienced brutal apartheid and forced migration. Hart describes three to four decades of economic and social change and struggle, advocated by what he terms “socio-spatial engineering and contesting space for industrial decentralization programs” (Hart 2002:1). A parallel can be found in the East African Region, where the current study area portrays similar processes, related to the legacy of colonial patterns. Recent decades have seen a restructuring of the economy in many Sub-Saharan countries, including Kenya and Tanzania. Structural adjustment programmes have been implemented, and the neoliberal approach that guided the programmes has resulted in a deregulation of the market, increased privatization and a slimmed public sector (Helgesson 2006, Bryceson 1997).

Mshana (2002) notes that one of the impacts of neoliberal policies in Tanzania was that health services became expensive for the majority. In addition, the downsizing of the public sector and deregulation of markets in East Africa have made people turn to the informal economy as a means for making a living and to diversify the household economy (Helgesson 2006), a process defined by Bryceson (1996, 1997) as deagrarianization rather than deindustrialization. These

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trends are seen in urban as well as rural areas. Rural dispossession (privatization of land, new forms of land use and natural resource exploitation) is not viewed as a past event but rather an ongoing process, which affects the lives of millions of the populace (Hart 2002). Acker (2004) echoes this, suggesting that in order to further understand global transformations, connections must be established between the local and the global, or the binaries themselves must be deconstructed (Acker 2004, see also Connell 2007 and Gibson-Graham 2006).

While predominantly discussing economic restructuring and trajectories of socio-spatial change based on a critical reflection on the concept of globalization, Hart (2002) provides tangible recommendations for land policy and activism. What she calls the “paradox of the adoption of neoliberal policies within local governance and land policy in a climate of extreme inequalities” offers a view into the recommendations to policymakers and activists to “disarticulate land from agriculture and rearticulate its significance in terms of its potential contribution to a social wage” (Hart 2002:305). Bryceson (2002) additionally advocates probing the complex interplay of economic, social, cultural and political dynamics in rural Africa, asserting that it is becoming all the more essential to understand this interplay for effective rural policy formulation. Hart (2002) and Mamdani (1996) converge on problematizing the rural/urban political divide, a division that has negative effects for rural populations. There is an absence within land policy of strengthening rural and urban linkages on the premise of rural empowerment and democratization. A pointed critique can be found in Mamdani’s analysis of the radical separation between economics and politics in the context of homeland regimes in post-apartheid South Africa (Mamdani 1996).

In the analysis by Cooper (2001), globalization in the African context can be portrayed in the form of transatlantic histories as well as more recent structural adjustment trends, whereby a ‘globalizing’ language stands alongside a structure of domination and dependent economic systems. In this context, Gibson (2004) situates traditional knowledge in relation to increased mobility and economic dynamics, where rights to traditional knowledge and resources are determined by historical and temporal as well as geographical and spatial dimensions. Historical pre-existing circuits of commerce may have facilitated contemporary exchanges
of traditional medicinal products and knowledge in the Eastern Lake Victoria Region.

My study area has similarities to the Australian situation as discussed by Hancock (1999) in Fatnowna et al. (2002). The past decade has seen national public service economies in conflict with an increasing privatization and neoliberal marketization of public service amenities including health and education. The privatization and commercialization of health are translating into an expanding business sector, with varying participation of actors at all levels within the health and business sectors. The marketization further involves varying degrees of commerce and commodification of natural resources, and is argued to weaken local communal cohesion. Within communities, individuals emerge claiming rights to a commercial value over what have previously been communal resources (Gibson 2004). The process of neoliberal globalization includes agency involvement by government states, individual persons/-communities and companies engaged in land resources, cultural heritage and traditional knowledge, including TMK. In this context, Shiva has a related discussion on bio piracy (see Shiva 1997), which reviews the appropriation of biodiversity from biodiversity-rich biomes, a theme widely discussed in policy and research (though I do not discuss it in depth in this study).

3.2 Rural-urban tensions, place and traditional medicinal knowledge

Despite the importance of TMK for both rural and urban populations, few geographers have investigated its practices in their socio-spatial dimensions. Research on TMK has examined the medicinal properties of different plant species while the social, economic and locational aspects have received less attention. The commodification of TMK must also be seen in the light of urbanization and migration processes. These processes, which also affect and are affected by people's place attachments, have meant an increasing focus on the commercialization of TMK and products.

As in many other parts of Sub-Saharan Africa, people in the Eastern Lake Victoria Region are increasingly moving to the cities. Geissler et al. (2002) show that,
despite a long history of out-migration, Luo people working outside Nyanza retain strong connections with their rural homes and are expected to build and maintain houses and relations there. This is also the case with the Sukuma in Mwanza (Brandström 1990). The majority of the population in Kenya and Tanzania - as is the case in many Sub-Saharan countries - live in rural areas, though high urban growth is taking place in this region. Research has shown that a predominantly youthful population is migrating to and occupying the urban space. Historically, predominantly young male labourers migrated in this region, engaged in plantation and export-oriented economies which produced raw materials, destined for export to industrializing core states. The youth provided the bulk of migratory groups from predominantly rural to rural as well as rural to urban places. Research by Oucho et al. (1993), Ochieng (1997), Swantz et al. (1996), Ogot (1963) and Helgesson (2006) has analysed the patterns of internal migration, urbanization and population distribution. The elderly as well as children and women remained in the rural place and maintained livelihoods that relied partly on remittances from male migrants.

Post-colonial governance structures have generally sustained the continuance of general migration and related urbanization trends in the region, with services and opportunities centralized within the major towns and cities in Kenya and Tanzania. The life strategies and approaches of young mobile people moving to urban areas continue to be influenced by national governing structures, which in turn are affected by international organizations and global governance structures.

Tanzania’s neoliberal policies were initiated in the mid-1980s, while Kenya’s liberalization dates to the late 1970s/early 1980s. The economic crises of the 1970s and 1980s affected many Sub-Saharan countries, and structural adjustment programmes (SAPs) were agreed upon by governments and Bretton Woods institutions in the 1980s (Swantz et al. 1996). These meant that the urban populace, more dependent on wage economies (linked to government jobs) than the rural populace, increasingly engaged in alternative livelihoods as wages became unsustainable. Subsequent effects of SAPs in the form of downsizing of governmental structures meant that waged economies became increasingly less viable as livelihood strategies for urbanized populations, including the youth.
These economic crises had rural-urban dimensions. The urban populace were especially vulnerable due to their dependence on wages and economies, as opposed to rural populations, who were partly dependent on agricultural production and remittances from migrant labour in the urban and rural spaces. The traditional role of a remittance economy altered, with changing livelihood strategies. The informal economy therefore increasingly provided a livelihood strategy for both the urban and rural populace, as described by Bryceson (1996, 1997). Mwamfupe’s research on labour and livelihoods in Tanzania discusses the diversification of the household economy as an ongoing strategy in both urban and rural populations, involving aspects of de-agrarianization and rural employment. Circulatory migration includes the youth who participate in return migrations to try their luck in rural-based livelihood activities. Capital acquired from these urban areas may not be enough to sustain a family, so it is brought to rural areas for investment in non-farm activities (Mwamfupe 1998).

Rakodi (2002) argues that the economic benefits of globalization have largely bypassed Sub-Saharan Africa and its cities – the latter have become increasingly sidelined by the prosperous sectors of the new global economy. Swantz & Tripp’s (1996) and Francis’ (1995) research show the increased role of informal economies and its social, economic and political implications. The new neoliberal policies changed the structures of export commodities, which had consequences on rural and urban economies, as prices for agricultural produce (tea, coffee, sisal, hides and skins etc.) declined. Urban populations increasingly diversified in informal livelihood strategies to supplement declining wages, and urban farming became a supplementary livelihood strategy (Swantz et al. 1996). Laurenco-Lindell (2002) terms this diversification more broadly as the reinvention of traditional socio-cultural practices in order to deal with the challenges of contemporary urban life. She further defines the above as a new wave of informalization in African cities, and asserts that informality now constitutes a pervasive feature in most cities, while formal mechanisms are reported to regulate but a small part of urban relations and dynamics.

Diversifying strategies were also applied in rural areas, including strategies to market traditional medicinal products in the urban areas. Jeruto et al. (2008)
and Wondwossen (2005) discuss the growing urban market economy for traditional medicinal products in this region. This partly redefines some of the practices of TMK and highlights TMK as a livelihood opportunity in urban areas, in terms of not only the TH profession but also marketing the products and providing income from them in the rural areas. The youth are thus beginning to seek to explore the profession of TH as a livelihood strategy with economic gain within both the rural and urban contexts.

These migratory tendencies, urbanization and a demographic shift have a combined effect of an increasing gap between the youth and the older generation. Perhaps dynamism in the aforementioned societal processes invokes what Cole’s (1996) “prolepsis” defined as changes in relations and social values between the young and old. These emerging livelihood strategies are unarguably important for the youth and their place relations, and may pose a threat to the sustenance of some traditional learning practices of TMK.

Research on place and space in relation to indigenous knowledge discusses how it is inherently tied to the land; not to land in general but to specific landscapes, landforms, or biomes where ceremonies are properly held, stories recited, medicines properly gathered, and transfers of knowledge properly authenticated (Morphy 1995). The place and space of Uluru Northern Territory in Australia exemplifies indigenous knowledge and its related learning as place-based and related to history, language and social relations. It views a place with specific landscapes, landforms and connectedness dimensions. Materially as a rock, it is known to the Aboriginal people as Uluru, a place of spiritual connectedness, a sacred place; while to others it represents a place of tourism, a physical challenge or simply a rock in the middle of nowhere (Anderson 2010:90). Frawley (1999) recognizes the interconnectedness and understanding of place and space as part and parcel of Aboriginal knowledge processes as follows:

For Aboriginal Australians nature and culture are inextricably bound together in the Dreaming - the time when the world, including Aboriginal people and their law, was created. Belief systems associated with the Dreaming link, specific places with Dreaming events, and give every person, living and dead, a place within a physically and spiritually united world. The landscape is not,
therefore, a composite of external objects, but is made up of culturally defined features of mythical significance (Frawley 1999: 272).

Geissler et al. (2002) express a similar understanding, more specifically with focus on place attachment in relation to TMK among the Luo:

As the power of medicinal plants resides partly in relations between place and people, dead and living, past and present, people have special ties to plants of their place. Young wives return to their parental homes to collect medicines for their children; townspeople receive medical supplies from rural homes; Luo migrants abroad consult Luo healers. Herbs, like food and earth, are ties across space and time; embodied relations, growing and engendering growth (ibid: 608).

The above research issues are further discussed in the empirical Chapter 8, where forms of learning TMK are analysed in relation to place and mobility. I will examine how learning processes linked to training apprentices in specific places are partly altered with new mobility patterns, land policy shifts and ecological aspects, which increasingly dictate the place and space of ritual sites.

3.3 Commodification and intellectual property rights

One key query within research on intellectual property rights (IPR) and traditional medicine is whether tangible and non-tangible elements of TMK and indigenous health knowledge have the potential to be commercialized or have commercial value in relation to their identification and appropriation (Mgbeoji 2006, Vermeylen 2008, Oguamanam 2006). The issue of IPR and the access to and use of TMK emerges as a highly contested arena, particularly when seen in the light of the commodification and economics of TMK. Estimates show the current world market for herbal products to be USD 60 billion, and it is expected to grow to USD 5 trillion by the year 2020 (Mashelkar 2002). Globalization processes within IPR regimes converge, with powerful organizations lobbying governments to accede IPRs that ensure increased profits. While figures estimate huge revenues to the North’s pharmaceutical industry, Mashelkar (2002) argues that not even a small fraction of this is ploughed into the developing world. Scholarship discloses some of the concerns of the developing world as the appropriation of elements of the collective knowledge of societies turn into
proprietary knowledge for the commercial profit of a few. Zerda Sarmiento et al. (2002) discuss how dominant research and trade organizations may obtain, develop and claim propriety rights and market products of vernacular knowledge on traditional indigenous practices. However, communities contributing to this knowledge seldom receive compensation (Brush and Stabinsky 1996).

The commodification of TMK is currently based on an intellectual property rights regime that is premised on private ownership and individual innovation. Personal or individual property rights in conventional jurisprudence are not applicable to certain indigenous and traditional intellectual interests due to the presumption of a relationship between the right holder and the object, which can be irrelevant in the context of community differentiation and access (Gibson 2004). The argument is that the current regime enters a conceptual conflict with traditional and indigenous knowledge in general and TMK specifically (Kamau et al. 2009, Mgbeoji 2006). In addition, there appears to be great hesitation to create new systems (sui genesis) for their protection (Mshana 2002).

While issues related to the economics of community knowledge are truly complex (Mashelkar 2002), the contemporary IPR regimes are at odds with indigenous knowledge that emphasizes the collective creation and ownership of knowledge. A consensus in research seems to be that indigenous communities lack a notion of individual private property over resources or knowledge. However, research by Zerda-Sarmiento et al. (2002: 102) provides examples of THs who take advantage of widespread ignorance surrounding the curative or magical ‘powers’ of indigenous medicine and use indigenous medicinal knowledge in communities for their own individual benefit. Zerda-Samiento et al. (2002) nevertheless disclose that while property has intangible and spiritual manifestations, nature as a constitutional continuum with its holistic version disallows the segmentation of its parts to become a community member’s individual property. The exchange of traditional medicinal products has occurred throughout the ages, within the context of trade, local markets and informal exchange of services, but profit and wealth accumulation were not systematically incorporated in the early gift economies (Smith and Wray 1995:163). Over time, however, contemporary
market dynamics have become integrated with the legacies of gift economies embodied in practices of TMK.

Critical researchers such as Shiva (2001) and Mshana (2002) discuss the patenting of genetic resources and TMK and argue that, contrary to the arguments of the pharmaceutical industry, this can in fact hinder progress in medicine and public health. They refer to studies that show that patenting increases the cost of health care and promotes unsustainable agriculture and unsustainable consumption. At the practical level it has proven difficult for communities to protect their intellectual property rights through the contemporary patent system, due to the unequal power relations between them and the cooperate world and the high costs of litigation. This seems to be the crux of the matter in the commodification of TMK. Later in the thesis I discuss how THs perceive proprietary issues and the potential progressive and substantial returns to the communities and healers who are viewed as holders of this knowledge.

Vermeylen (2008) formulates a central research question when she asks to what extent the ongoing commodification of TMK and products challenge and/or undermine TMK systems, which are embedded in distinct socio-cultural and socio-economic contexts. As she puts it:

[T]he growing (commercial) interest in traditional knowledge raises the question whether it is possible for traditional knowledge to be commodified and become valuable to the larger world without posing a threat to the social structures that sustain this knowledge and the livelihoods of indigenous peoples who depend on it (ibid: 2).

Similarly, Oguamanam (2006) is one of the researchers who in theoretical debates argue that the Western intellectual property model poses an epistemological and moral conflict with indigenous knowledge systems and worldviews. He describes how the commodification of knowledge in an industrial model approach is extended to biological resources, with intellectual property rights promoting commodification by rewarding the physical manifestation of knowledge and ideas. Indigenous peoples, in contrast, maintain that their relationship with ecological forces is sacred and transcends economic utility or
the allure of market forces (Oguamanam 2006). In the same light, Posey (2002) advocates research on intellectual property rights for the reversal of global trends that substitute economic and utilitarian models for the holistic concept of the ‘sacred balance’. Gibson (2004) contributes that the Australian indigenous peoples are in possession of a rich TMK base, in the context of a developed nation. This case problematizes assumptions of tradition against innovation, developing against developed, and is viewed as an important case of examining the relationships and tensions between TMK for the local communities, for the national interests and for the interests of commercial bodies.

The commodification of indigenous knowledge and medicinal plants obviously involves a number of complex issues including plant protection, the intellectual property rights of indigenous peoples and the ethics of commodification. International policymakers are developing new principles and guidelines for protecting indigenous knowledge from predators and bio piracy (Shiva 1997, Battiste 2002). These policies address matters as diverse as food and agriculture, the environment, notably the conservation of biological diversity, health including traditional medicines, human rights and indigenous issues and aspects of trade and economic development (WIPO 2005). Voeks (2007) discloses that, parallel with the resurrection of respect for THs and the criticism of bio piracy, there are initiatives by government agencies, pharmaceutical companies and scientists to fashion systems of reciprocity that benefit a range of stakeholders.

In the next section I discuss research on the issue of global access and benefits to resources and intellectual property rights that emanate from TMK and products.

3.4 The emergence of an international regime on intellectual property rights

Recent reports and documentation show that the South African Government’s contemporary discourse in addressing intellectual property rights and access and benefit sharing provides some of the most illustrative examples of legislative framework in Africa. Below I go into some detail concerning a South African example of handling the relationship between TMK and intellectual property
rights, as it is the first of its kind in the African context, and is thus highly relevant for both Tanzania and Kenya. The following citation describes the case:

Water and Environmental Affairs Minister, Ms Buyelwa Sonjica, will preside over the ceremonial handover of the first bio prospecting licence to HGH Pharmaceuticals (Pty) Ltd in Khwa Ttu in the Western Cape this Friday, 1 October 2010. The event forms part of the minister’s Public Participation programme. The bio prospecting licence, approved by the minister on 8 December 2009, grants HGH Pharmaceuticals (Pty) Ltd local and international research on cultivated plant material and extracts from Sceletium tortuosum which is commonly referred to as kanna, channa or kougoed and to commercialize the product for central nervous system conditions. The San peoples are acknowledged as the primary indigenous knowledge holders of certain medicinal and other uses of Sceletium. South African San Council (SASC), Paulshoek and Nourivier communities are the patients of the commercialization of the Sceletium tortuosum product. A benefit sharing agreement is in place. This product has been used by nomadic pastoralists and hunter gatherers as a mood altering substance from pre-historic times. According to National Environmental Management Biodiversity Act (NEMBA), ‘no person may trade commercially on any indigenous biological resource from South Africa without a permit ensuring sustainable harvesting issued by the minister’. The awarding came as South Africa prepared to participate at the tenth meeting of the Convention on Biological Diversity (CBD) held in Nagoya, Japan from 18 to 29 October 2010, where it would be considering an extensive agenda that would include the adoption of an international regime on access and benefit sharing whose negotiations are at a critical stage’ (Indigenous Peoples Issues and Resources, accessed September 30 2010).

The citation outlines a country-specific example from the Republic of South Africa, where official government institutional policy and legislation have been proactive in addressing contemporary issues regarding the access and benefit sharing of traditional knowledge systems in general and TMK specifically. The above exemplifies the institutionalization of TMK resources of an indigenous San community. It defines the concluding phase of what has been a series of negotiations between ‘owners’ of indigenous or TMK, the national formal governance structures in South Africa and a multinational pharmaceutical company. For the purposes of this study, it exemplifies a growing number of

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10 The San are an indigenous people who live in an area spread across Southern Africa, in Botswana, Zimbabwe, Lesotho, Swaziland, Mozambique, Angola, Namibia and South Africa. Their 40,000-year history makes them the oldest people in southern Africa. Some of the San people inhabit the Kalahari Desert and, having a migratory hunter-and-gatherer socio-cultural lifestyle, are well known for their intense and advanced traditional medicinal knowledge developed over centuries and adapted to some of the harshest environments on Earth. The San chew on the bitter Hoodia cactus, which is endemic to their environments, to suppress hunger and thirst during hunting. For further reading, see The Hoodia Story (2012-06-19).

11 Traditional or indigenous knowledge holders do not consider themselves ‘owners’ of the TMK but rather as its custodians for the next generation, as evidenced in this empirical study and scholarly readings in anthropology and law. Thus, the term is used here for the purposes of the understanding of ownership of patent rights in a commercial sense. For further reading, see Oguamanam (2006) and Mgbeoji (2006).
reports on the international debate and dialogue portraying globalization processes, including global governance and corporate structures, national bodies of governance and local communities with regard to intellectual property rights and access and benefit sharing (ABS) regimes as well as bio prospecting on TMK. While the San community was successful in negotiating a benefit sharing agreement, other communities have not been able to do so. Below is the example of the Khwe, who express how they have no control over their resources, particularly the medicinal plant called the “devil’s claw”, which today has been widely commercialized:

While there are still sizeable quantities of ‘devil’s claw’ buried deep in the sandy soils of Bwabwata Park, increasing development, mass-tourism, climate change and pollution are real threats to the area’s biodiversity. The Khwe could be instrumental in protecting precious natural resources, but politics and the market are working against them. ‘We have so many resources, but we don’t control them,’ comments an IRDNC field officer ‘Why are our rights limited like that?’ (IRDNC 2012).

The above two contexts exemplify the contemporary issues at the global, national and local levels where IPR, ABS and bio prospecting on TMK exist in a contested arena. The contemporary governance structures and commercialization of TMK are identified as entailing obstacles to the community’s institution with regard to its local TMK and ABS regime. This is based on the premise that for these communities, patents or other forms of IPRs on the living organism have profound implications on communal livelihoods that have sustained African communities and others for generations (Githae in Kamau et al. 2009).

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12 For an elaboration on definitions on intellectual property rights (IPR), access and benefit sharing (ABS) International Regimes and Bio Prospecting- see Chapter 2 of this study.

13 Devil’s claw (Harpagophytum) is a traditional medicinal plant endemic to Namibia and Southern Africa. Most of the world’s supply comes from Namibia, Botswana and South Africa. It is traditionally known for its properties to cure fever, rheumatoid arthritis, skin conditions and conditions involving the gallbladder, pancreas, stomach and kidneys. The primary use of devil’s claw today is for conditions that cause pain and inflammation: back and neck pain, rheumatoid arthritis, osteoarthritis. According to a study in the Journal of Ethnopharmacology, sales of devil’s claw in Germany were estimated at 30 million Euros in 2001, accounting for 74% of the prescriptions for rheumatism. See Wong K, http://altmedicine.about.com/od/herbsupplementguide/a/DevilsClaw.htm, accessed 2012-03-16.

3.4.1 TMK and globalization processes on intellectual property rights

The role of intellectual property (IP) systems in relation to traditional knowledge, and how to preserve, protect and equitably make use of this knowledge, has recently received increased attention in a range of globalized international policy discussions. Recent research on TMK has been in focus in relation to intellectual property rights (Githae in Kamau & Winters (eds) 2009), while being a field with many contesting interests between various actors: multinational companies including pharmaceuticals; national governments; THs; and traders in traditional medicinal products. These address matters as diverse as food and agriculture; the environment, notably the conservation of biological diversity; health, including traditional medicines; human rights and indigenous issues; and aspects of trade and economic development (WIPO 2005). The politics of plant patent are played out more at the levels of food, seed, agriculture and horticulture than with respect to health and medicine (Oguamanam 2006). This scholarship indicates that TMK practices involve most aspects of intellectual property rights, though comparatively, the patent regime bears the closest relevance to TMK and is the most discussed regime of intellectual property in relation to TMK (Oguamanam 2006).

Intellectual property rights are granted to individuals or juridical persons who claim to be inventors or creators. Such rights may apply to a broad range of creative expressions, designs, products and processes, provided that certain requirements and conditions are met (Oguamanam 2006). With regard to patents, the claimed inventions must be novel (that is, not publicly available or disclosed); convey an inventive activity; and, in most jurisdictions, be capable of industrial application (ibid). This has significant relevance to TMK, as the acquisition of patents on traditional medicine is a key contested arena for the industry, including pharmaceutical companies and multinationals, in order to produce and market refined plant material. For trade secrets, the knowledge must be of actual or potential commercial value (WIPO 2005). Although there is no reason such categories of rights may not apply to various expressions of

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15 See Oguamanam 2006.
16 See Oguamanam 2006.
traditional knowledge, including traditional medicine, there are several characteristics of traditional medicine that create barriers to protection through the use of existing forms of intellectual property right regimes.\textsuperscript{17}

On the international arena, the Nagoya Protocol\textsuperscript{18} and the adoption of an international regime on access and benefits sharing marked a milestone agreement and the latest in a series of global meetings in the past decade. This Protocol states and recommends internationally agreed upon legislation and protocol on access and benefit sharing principles to be applied at all institutional levels, including local communities, which are repositories of TMK and indigenous knowledge. The Protocol draws on the Convention on Biodiversity and stipulates legislation that should be adopted by national governments on the governance of bio prospecting regimes (see the Nagoya Protocol\textsuperscript{19}).

Two principle international regimes that recognize the central role of patents as the most pertinent intellectual property regime in the context of TMK are the World Trade Organization’s Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) and the Convention on Biological Diversity (CBD) (Oguamanam 2006). TRIPS is a key international agreement promoting the harmonization of rules of protection of national intellectual property rights regimes, and covers seven types of intellectual property rights: 1) patents and plant variety protection, 2) geographical indications, 3) undisclosed information (trade secrets) and control of anti-competitive practices, 4) trademarks, 5) copyright and related rights, 6) industrial designs, and 7) layout designs of integrated circuits (Mshana 2002).\textsuperscript{20} This agreement is problematic, however, as it does not acknowledge or distinguish between indigenous, community-based knowledge and that of industry (Oguamanam 2006). Furthermore, it makes no reference to the protection of traditional knowledge and is in direct conflict with the basic tenets of CBD in that it formalizes the trend in which IPRs confer private, individual and exclusive ownership on life forms (Githae in Kamau et al.

\textsuperscript{17} See Oguamanam 2006 and Kamau & Winters (eds) 2009 for further reading.
\textsuperscript{18} The Nagoya Protocol of 2010 is the latest in a series of international meetings adopting an international regime on the access and benefit sharing of biodiversity resources. See http://www.cbd.int/abs/
\textsuperscript{19} See : www.cbd.int/abs/
Conceptual objections include the fact that the capitalistic orientation of conventional intellectual property rights is in apparent conflict with the communal nature of ownership and the socio-cultural structure of indigenous societies. The strict individualistic constructs of property in the Western mould do not fit into indigenous ideals\(^\text{21}\) (Brush and Stabinsky, cited in Oguamanam 2006).

The Convention on Biological Diversity is the only major international convention that assigns ownership of biodiversity to indigenous communities and individuals and asserts their right to protect this knowledge. The fair and equitable sharing of the benefits arising out of the conservation and utilization of genetic resources is one of the three objectives of the Convention (see CBD\(^\text{22}\)). This Convention represents the most authoritative binding international instrument to create a global regime to give access to genetic resources and share the benefits of their use, while it provides a framework for the evolution of national and regional regimes. Though it recognizes the traditional knowledge of indigenous and local communities, the criticism of some aspects the Convention is that ‘[...] as a Regime aimed at the conservation of biodiversity, it is also aimed at facilitating its exploitation and even commercialization’ (Githae 2009, Oguamanam 2006).

**3.5 Research on the commodification of Ayurveda**

Nazrul (2010) analyses the process of commodification and its ‘ally’ consumerism with regard to Ayurvedic medicine in India. In this process, patients and the general public have become ready consumers of Ayurvedic health products. Nazrul shows how, in a twin process of commodification and consumerism, large pharmaceutical companies have appreciated Ayurveda and redefined the nature of Ayurvedic drugs and drug production for profit maximization. Bode (2006) terms this a transformation of Ayurvedic and Unani formulas into mass-produced goods that are distributed, traded and consumed. In the arena of the

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\(^{21}\) Brush and Stabinsky contest IPR as tools of capitalism, arguing that the idea of intellectual property for commoditizing knowledge and plant life, and biological prospecting, are part of a rush to capitalism in times of aversion to common solutions to public problems’ (Brush & Stabinsky (eds) in Oguamanam 2006).

\(^{22}\) http://www.cbd.int/convention/text
marketplace, Indian medical traditions and their healing substances have been commoditized (Bode 2006). The commodification of Ayurveda can exemplify a broader trend, as Nazrul (2010) notes:

(W)ith the steady growth of local and international market for herbal-based drugs, health supplements and beauty products, Ayurveda has been propagated as a natural healing system, and Ayurvedic medicine/health products are featured as natural remedies, which equates ‘herbal’ with Ayurveda, and people often misunderstand herbal products as Ayurvedic products. This entire situation has ideologically ‘contaminated’ Ayurveda, with Ayurveda having lost ground as a complete way of healthy life to restore and maintain health (Nazrul 2010:1).

In *Vanishing Physicians and Shortage of Traditional Medicines*, Bode (2006) discusses how over the past 25 years the market has shaped, constrained and transformed India’s largest medical traditions, Ayurveda and Unani Tibb. An increasingly affluent consumer middle class within the urban populace has favoured this trend. While the commoditization of Ayurvedic and Unani formulas threatens to rob the poorer sections of Indian society of access to Indian medicine - because they cannot afford the commoditized and relatively expensive Ayurvedic and Unani brands - the proliferation of over-the-counter brands is also eroding the position of the traditional physician. Bode (2006) discusses the erosion of patient-TH dynamics in the commoditization process, a phenomenon highly relevant for my study:

The Traditional Physician’s expertise in diagnoses and tailor-made treatments is not used. This jeopardizes the efficacy of Ayurvedic and Unani formulas, because in the heuristic approach of humoral medicine the physician–patient relationship is crucial for the efficacy of therapeutic substances. In humoral medical traditions such as Ayurveda and Unani Tibb, life-style changes and personal empowerment are important elements, which ideally speaking, Ayurvedic and Unani physicians are humoral experts and wise men all in one. They inspire patients to turn to more healthy lifestyles and reformulate social identities. Both are important elements in the treatment and acceptance of chronic, degenerative and mental diseases, ailments for which Asian medicine has a lot to offer (Bode 2006:234).

The role of the TH may thus be redefined with commodification, as shown in research from different parts of the world (see also Swantz et al. 1996). THs often say that their job is their destiny, a destiny to serve the common good. In the Tanzanian context this is expressed as being *Kipaji* having a God-given gift.
Because of this gift they have no choice but to heal people in need, as opposed to making money. THs can be suspicious of the credentials of healers who use their occupation as a means of making money to benefit themselves as individuals. Bode (2006) discusses the gift within the context of the Indian Ayurveda and Unani TMK, where Ayurvedic and Unani medicines become signals of wisdom and are conceptualized as gifts to an ailing humanity by Hindu rishis (seers) and Muslim tabibs (wise men).

3.6 Gender and traditional medicinal knowledge – a growing research field

Research from different parts of the world has shown that gender awareness is central in understanding forms of use and management of natural resources. Thus different customs, values, norms and laws in different parts of the world have meant that there is a gendered work division between men and women with regard to TMK (unfao.org). Because men and women often travel and toil in different spaces, their familiarity with nature is bound to vary (Voeks 2007). Women and men quite clearly exhibit differing knowledge of their local flora, a difference that is especially pronounced in relation to tropical healing flora (ibid). Voeks states that women in Brazil, especially older women, represent the primary health care providers for the family and the community, a situation that prevails in many other regions in the developing world as it did, historically, among native communities in North America.

Huisinga et al. (2001) argue that the gender attributions of local knowledge, including knowledge for managing biological systems, have four key characteristics:

Women and men have knowledge about different things.
Women and men have different knowledge about the same things.
Women and men may organize their knowledge in different ways.
Women and men may receive and transmit their knowledge by different means.
I look at these characteristics in relation to what I found in my study in the empirical chapter on inter-generational learning and the concluding chapter of this dissertation. Despite these different characteristics, little of recent interest in indigenous knowledge learning systems has specifically addressed women’s indigenous knowledge (Sharp et al. 2003), which is also related to place-based gender norms. Mathai (2004) lamented that throughout Africa, women are the primary caretakers, holding significant responsibility for indigenous knowledge and biodiversity management for their families. As a result, they are often the first to become aware of environmental damage as resources become scarce and incapable of sustaining their families (Mathai 2004). Brock-Utne (2002) argues that in Africa the cultures and societies are deeply gender-rooted while the position of an African woman is relational in the extended family and kinship system rather than individually based.

Eyssartier et al. (2008) indicated that the transmission of traditional plant medicinal knowledge begins at an early age, often as a family custom, in which women play a predominant role, while the use of this knowledge continues to be learned during adulthood. Research also defines women as especially vulnerable to ailments such as STDs and HIV/AIDS as well as to other social issues and challenges linked to rapid socio-spatial transformations. Women often also constitute the majority of THs’ clients (Homsy and King 1996) apart from their predominant role in primary health care.

Research shows that in traditional matriarchal cultures, healing was associated with the life-giving capacities of women (Eisler 1989). For most of human history, in numerous indigenous societies holistic healing was practiced largely by women, whose knowledge of herbal preparations was as common as the knowledge of cooking today (Griggs 1982). Female healers in general have specialized in knowledge of traditional medicine used pre- and postnatal for the care of women and children. According to Eyssartier et al. (2008), women have played a role in transmitting not only their traditional knowledge but also certain values in relation to natural resources, generation after generation. Indigenous healing practices maintained by laywomen remain among the most important healing practices in most rural parts of the world.
While research increasingly recognizes the role of women in healing, Adamovicz et al. (1997) concur with others who have cautioned against romanticizing indigenous knowledge or customs - including women’s. They argue that women are not closer to nature simply as a result of their biology. If we wish to address the values of natural resources and traditional knowledge to local peoples, we need to gauge their attitudes to them. Many cultures have practices that use natural resources unsustainably. Social and economic hierarchies exist within communities, even among women, due to disparities in access to resources and economic opportunities (McDowell 1999).

Anderson (2000) argues that the conscious or subconscious adoption of Western patriarchal ideologies by indigenous peoples cannot be measured, but is worth acknowledgment. The best indicator of how patriarchy has transformed traditional and indigenous knowledge systems in general and medicinal knowledge specifically is found by analysing indigenous women’s economic status and social standing. This standing has been evidenced as critically poor by numerous researchers (Anderson 2000, Gunn Allen 1986, McGillivray et al 1999, Smith 1999, Dei et al. 2000).

According to research by Carter (1996), Aboriginal women who are significant holders of TMK have been both formally and informally marginalized through legal, social and economic intrusion. Odora Hoppers (2002) in turn discusses how the cosmological knowledge of women ‘Others’ has historically often been undermined, particularly knowledge of phenomena that could not be measured through various scientific methods. The impact of colonialism on indigenous women’s role in TMK and ceremonials has not been addressed specifically in research literature. This notifies us of a gap in the traditional medicine literature, which according to Carter (1996) has historically often been generated by Eurocentric male patriarchal writers who tended to dismiss women’s work altogether.

Dei et al’s. (2000) research on feminist praxis in transformative learning discusses indigenous healing practices maintained by laywomen. According to
WHO, traditional medicinal/therapeutic knowledge is entrenched in and constitutes aspects and practices of a people’s socio-cultural and religious identity, worldview and understanding that are indispensable to indigenous and local communities in dire need of health care (see Dei et al. 2000, Oguamanam 2006). This is further echoed in Lux’s (2001) research on documentation of TMK, which cites numerous examples of historical records and archives documenting women’s medicinal knowledge and practices in Plains culture.

Lux (2001) discusses, for instance, the nature of healing in Plains culture among traditional birth attendants while she elaborates on the high social standing of Plains midwives, and how they performed not only prenatal but also postnatal care for woman and child, continuing for months after the child was born. In her writings on women and First Nations, Carter (1996) elaborates on the TMK of Prairie Aboriginal women as being widespread. Written historical documentation by local doctors suggests that medical doctors’ and settlers’ use of traditional midwives and healers was a common practice on the frontier. Citing numerous examples of indigenous women assisting medical doctors with births for native and non-native women alike, the life of aboriginal/indigenous women’s historical role in healing is brought to bear.

In this thesis I discuss gender and TMK within the Luo and Sukuma societies, both of which are societies in which marriages are characteristically exogamous and virilocal, and in which polygamy is practiced. I will particularly highlight gender in my analysis of learning processes, in which the role of women married away from their clans has been important.

3.7 Research on intergenerational learning of traditional knowledge

Research on learning processes within traditional knowledge systems has analysed both the challenges and opportunities of these practices in different contexts. Indigenous knowledge is viewed as a growing field of inquiry, both nationally and internationally, particularly for those interested in educational innovation (Battiste 2002). Indigenous knowledge pedagogy is characterized by intergenerational learning, which is largely place-based and related to history,
language and social relations. Intergenerational learning can be broadly defined as the different forms by which knowledge is passed on between generations, and is the dominant form of learning within indigenous knowledge systems. WHO defines how traditional knowledge transmission often relies exclusively on practical experience and observations handed down from generation to generation. Transmission is generally oral, but may also be textural (Mashelkar 2002). While rather few studies have looked at the importance of place and space in medicinal learning processes, there are recent important contributions by Lindstrom and Muñoz-Franco (2005), who studied the impact of out-migration on certain types of health knowledge, and other researchers who point out how place and social networks are crucial for health knowledge transmission (Glewwe 1999, Andrzejewski et al. 2009). Glewwe (1999) has shown that little medicinal knowledge is taught in formal schools; instead, the acquisition of literacy and numeracy skills may foster health knowledge learned “outside the classroom”.

Indigenous epistemologies are narratively anchored in communities, while indigenous knowledge is shared and communicated orally in the indigenous language through specific examples and through socio-cultural practices (Hammersmith 2007). Education and intergenerational learning have been viewed as having moral and material dimensions, with oral modes of learning from elders playing a major role in its sustenance (Ntuli 2002). There is thus intense responsibility involved in knowledge transmission, as noted by Coombes et al. (1983):

The nature of that knowledge and the person involved in its transmission determined the who and what of that process [...] the transmission of this knowledge within and outside the group was also subject to many different protocols and considerations of internal and external management of knowledge. Rights in knowledge, were political, economic and religious, and mediated in large part by responsibilities attached to kin relationships (Coombes et al. 1983:88-91).

Governance structures of oral cultures and oral narratives with their related complexities thus aid in the maintenance, management and transmission of
knowledge, and these structures could assure the continuity of learning processes within and between generations. Kinship and intergenerational relationships are central in providing coherence and situating these governance structures.

3.7.1 Oral pedagogy in intergenerational learning

Hammersmith (2007) argues that forms of communication within indigenous knowledge systems are basically oral and are as such vital to local level decision-making and to the preservation, development and spreading of knowledge. The role of oral pedagogy has been documented in research on indigenous learning processes among, for instance, the Maori in New Zealand, First Nation groups in North and South America, and Aboriginal Groups in Australia, Asia and Africa. Mirambo’s (1999) research on the Sukuma context of oral narratives indicates that while usually extremely entertaining, these oral stories often have a role of teaching, warning, instructing and setting qualitative standards, while they express the mindset of the people. As Mirambo describes, concerning the Sukuma:

Themes in these oral narratives/folktales which usually contain and relate a variety of messages, while being rich in style, may mainly include traditional cultural issues and human behaviour. Sukuma narratives include a variety of myths, ogre stories, spirits (shing’wengwe), animal races (Mirambo 1999:4).

Analyses by Ntuli (2002) and Mirambo (1999) show that among the Sukuma, children of different ages and from different families come together during playtime and sing, tell stories and engage in riddling activities. These activities entertain children, besides making them creative. Such a pedagogical mode based on oral narratives, though becoming increasingly less used, can and has been argued to aid youth in growing up according to societal expectations. In other words, it may help prepare youth to take control of their lives within the broader society (Ntuli 2002). Pedagogy within oral narratives emphasizes what society “likes and what it hates” Mirambo (1999). The stories within oral narratives deal directly with the lives of different people – heroic ones, fraudulent ones etc. – while stories are based on beliefs about death, disease and suffering, animal
stories etc. The elderly have the responsibility to protect the young people and transmit to them the prevailing traditional knowledge.

TMK education includes obtaining proficiency in the identification, preparation, conservation, management and administration of the medicinal products. Over several generations, knowledge in the identification of plant species with medicinal properties and their use has been developed. Geissler et al (2001) describe how TMK among the Luo is usually imparted between alternate generations. They define learning to heal as:

(...) being embedded in the close relationship of reciprocity and care between grandmother and grandchild in Luo society. Through shared daily life with his/her grandmother, the child develops social sense, respect, and compassion for people, as well as practical skills. By showing that learning to heal is not only embedded in everyday practice and in social relations, but is also a moral and emotional process (Prince et al. 2001:1).

Some studies relate a direct association between maternal plant knowledge and child health, which may be mediated by the children themselves. Beyer (2009) describes how Tsimane' children in the Upper Amazon spend much of their time away from parental supervision, playing and foraging in small peer groups. Beyer argues that the fact that older children use medicinal plants for both themselves and younger children shows that plant medicinal knowledge — like so much other cultural knowledge — is passed not only from adults to children but also from older children to younger children. At present, this gathering practice tends to be declining over generations, as has been analysed in research on the Mapuche in Chile (Estomba et al 2005).

Training to become a TH usually starts in pre-adolescent age when the child is perceived as being receptive and obedient, having a good memory and being able to keep secrets (Mwiturubani 2009). Oral learning is dependent on practices that anchor memory in the (rhythmic, performative and ritualizing) body of the participants (Crossman et al. 2002). Oral transmission and learning depend on speech/rhetoric and the social status including the gender, age and role of the individual. The oral nature of the transmission ‘demands’ ethical and moral
responsibility, which is embodied through secrecy and sentiments about how life events should be interpreted.

The Aboriginal discourse in Canada and Australia sheds light on the extensive use of the oral and symbolic nature of indigenous knowledge, whose transmission to the next generation takes place through modelling, practice and animation “rather than through the written word” (Battiste 2002). Aboriginal scholarship defines protocols for ‘proper learning and teaching’, which have been documented in research with elders and educators describing the roles and protocols for telling Aboriginal stories. This is also expressed in Cora Weber Pillwax’s (2001) study on the Mi’kmaq in Canada:

Oral stories may be for and about teaching, entertainment, praying, personal expression, history and power. They are to be listened to, remembered, thought about, and mediated on. Stories are not frivolous or meaningless: no one tells a story without intent or purpose. A person’s word is closely bound up with the story that she or he tells...[...]. So words - in particular some words in some contexts - are not carelessly spoken. These are the old ways. And they are still practiced and observed today by many people in many places (Weber-Pillwax, 2002:25).

Aboriginal discourses on intergenerational learning thus situate elders, knowledge keepers, and workers competent in indigenous pedagogical approaches as living educational treasures. They are viewed as treasures because their temporal and spatial contexts are limited in a time of rapidly changing dynamics in societies.

3.7.2 Contemporary challenges to and opportunities of intergenerational learning

Battiste (2002) notes that scholarship exploring indigenous pedagogy and epistemology is limited in scope and depth; but there is important scholarship on, for instance, the Australian and New Zealand Aboriginal and Maorian contexts, as well as on First Nation intergenerational learning in the Canadian context. The Australian Aboriginal scholarship has highlighted the elders’ concern and considerable anguish that few young people want to know the “old stories” and that few are considered to be appropriately prepared to have these passed on to
them (Fatnowna et al. 2002). These researchers also point out that today in Australia most Aboriginal communities live in urban areas, which in many cases complicate contact between generations.

Challenges to intergenerational learning are analysed in Aboriginal and First Nation contexts, where perspectives concerned with the recovery and development of indigenous knowledge and pedagogy are common. These contexts are premised on the legacy of colonialism, which involved the conquering of physical space and the dislocation of peoples from their lands as well as the incorporation of indigenous learning into Western pedagogies. Associated with this was the separation of children from their parents, which caused discontinuity in intergenerational learning pedagogies. Bourke (1994:135) discusses the Australian case, which produced “a gap in the knowledge of many Aboriginal people, denied cultural continuity through policy of banning language and cultural practices, and the forced removal of children”. This research argues that uneven power relations between the periphery and centre within the national context are still real and present embedded within a contested arena of learning and education systems.

In New Zealand there is scholarship emerging from a Maori theoretical base, which has translated into practice in forms of Maori schooling, university studies and research. Smith and Smith (1997) articulate this aspect of the Maori struggles, which opens new opportunities to make and reclaim curriculum, pedagogical and institutional spaces for Maori, within both knowledge development and intergenerational learning.

South Africa has developed an institutional model of TMK of the so-called sangomas (THs), whereby knowledge transmission takes place within schools from which students obtain membership and graduate as sangomas (Thornton 2009). As we will see in the empirical Chapter 7, the learning processes in South Africa are formalized as opposed to those in the Kenyan and Tanzanian sub-study area.

According to Gush (2002), within the context of a prevalent extended family system, intergenerational relations and programmes on an entirely non-familial
basis are next to impossible. However, there are intergenerational programmes in South Africa that provide a platform to encourage a renewed role of the older generation in mitigation efforts related to HIV/AIDS. Multigenerational households are a predominant feature among the dominant population, and within these structures all young people were/are the responsibility of the older generation, irrespective of biological affiliation (Gush 2002). In the context of education the common saying is that *the child is educated by the community*, which speaks to the role of the collective in bringing up a young person. However, this extended family structure is partly changing in line with changing economic conditions and increased mobility, predominantly (but not exclusively) by the youth to towns, cities and rural spaces where they seek potential livelihood opportunities. In Chapter 8 I will further discuss the challenges presented by a loss of mutuality and reciprocity between generations in the learning processes.
4. Methodological considerations

4.1 Introduction

In general, choosing which research method to use depends on one’s research interests and questions. A study might also provide information for later policy interventions, which could build on the results and findings.

The research focus I have chosen, with its qualitative approach, has at least six reasons. Firstly, in my literature and documentation review I found that in Eastern Africa considerable scholarship has been devoted to traditional knowledge systems of medicine and medicinal plants (see Swantz et al. 1996, Mollel 1994, Brokensha et al. 1980, Jeruto et al. 2008, Wondwossen 2005, Langwick 2008, Good et al. 1980, WHO 2002, 2003). However, much less has been written about TH's practices and perceptions of their own practices and changing societal dynamics. Criticism abounds that even some of the most recent literature about traditional knowledge and intellectual property rights pays little or no attention to the variety of ideas and perceptions that can be encountered ‘on the ground’ (see e.g. Gibson 2005). Recent research on South Africa’s traditional medicine policy and legislation indicates that it appears to possess several community-empowering features, but needs more participation from communities (Gavriilidis et al 2012). Could empirical research in the field yield more knowledge about traditional knowledge holders: who they are, what they want and how they perceive commodification and intellectual property rights? There is now a consensus on the need to inject more empirical evidence into the dialectics on the commodification of traditional knowledge (Vermeylen 2008). I echo Langwick’s (2008) approach to addressing this:

Although my efforts to account for the historical and contemporary pressures that have shaped healing in Newala (Tanzania) did at times draw me into regional capitals, national headquarters, and a variety of archives in Tanzania and the United States, the majority of my research involved interviewing, observing, and working with healers and hospital staff in Newala. I conducted multiple intensive interviews with more than twenty-five healers and traditional birth attendants in the district of Newala in Southern Tanzania (Langwick 2008:91).
My enquiry therefore renders me to seek to unfold and understand the ways THs profession is being affected by the wider context of societal processes mentioned earlier in this thesis. Traditional medicinal knowledge includes norms, systems, attitudes, perceptions and behaviour, which constitute information that can mainly be obtained through interviews and observations in the field.

The second reason, which relates to the first, is that it is difficult to obtain and source information from THs. I identify three broad categories of healers: spiritists/diviners or religio-medical specialists; herbalists; and traditional birth attendants or midwives. However, even though THs can be defined in broad categories, they are mostly involved in multiple roles that correspond to the underlying, cultural, spiritual and religious belief systems in their societies (Oguamanam 2006). Their social position in general is that they occupy a powerful position of authority, and as such they have influence in the study area and in society in general. Given their position, it is therefore not surprising that walking into a TH’s workplace, with the aim of accessing information is not an easy undertaking. The information and knowledge about their profession and how it relates to the wider community is closely guarded, and healers often share this knowledge primarily only with individuals who are either close relatives and/or are to inherit the profession. Outsiders, including other THs and strangers to the area, are met with suspicion. Protected knowledge (e.g. medicinal plants) may require specific considerations, as in other cases when doing research on so-called Non Timber Forest Products (NTFP) (Douglas and Wunder 2002).

A third reason behind my focus is that traditional medicinal knowledge is largely unwritten. It is almost exclusively oral, with tacit knowledge constituting a large part of its context. I even encountered a TH who said that if he writes the names of the products and their use, the apprentices would forget! So his approach and perspective were to demonstrate and show the apprentices the practices and plant products and send them repeatedly to collect the products, which from his perspective would not necessitate writing down the names. The pedagogical methods used, the relationships between TH and apprentice, and the forms of
learning are of intense interest to today’s researchers. To access this knowledge, a defined qualitative approach is necessary.

A fourth reason related to the above is that official documents in Kenya and Tanzania state that ongoing socio-spatial dynamics could be transforming the role of the THs in the study region (see e.g. the National Health Policy in Tanzania, the National Strategy for Growth and Poverty Reduction of Tanzania 2011, and the Draft National Policy for Traditional Medicine and Medicinal Plants in Kenya 2008), but they do not tell the story at the grassroots level, and less still the perceptions of the THs. I concede that one form of qualitative methodology could be a way to access their perspective on these issues.

A fifth reason is that I consider it crucial to study TMK in the natural setting as a participant observer in the research process. I share Wolcott’s (1995) view of fieldwork as characterized by personal involvement to achieve some level of understanding that will be shared with others. The THs preferred to be interviewed in or within the vicinity of their homesteads, as this was close to locally available products and was their ‘comfort zone’. This was the case for both urban-based and rural-based healers. Urban-based healers were able to have discussions at their place of work, e.g. the marketplace or corner assigned to their trade.

The sixth and last reason is my interest in explorative research, which tries to focus on a specific space and place while discovering something new. In sum, using the chosen methodology is motivated by the kind of research data sourced, the nature of the research context, the focus of the research questions and what the respondents say, as well as the extent to which the researcher wants to dig into the scenario.

### 4.2 Thematic analysis of narratives

Following the process of designing the fieldwork interview schedules, during and soon after the fieldwork exercise I developed a better understanding of the potential for alternative qualitative approaches, which I could use. Insight into
Glaser’s (2001) distinction of Grounded Theory’s non-descriptive nature, which places less emphasis on the voices of informants and is thus less likely to be able to reflect the narratives of individuals due to its focus on categories, concepts and phenomena, prompted me to migrate away from this analytic framework toward others. This is because the main approach and aim of this study, as mentioned earlier, was to explore the voices and perceptions of THs regarding their medicinal practices in the context of socio-spatial transformations.

4.2.1 Narratives

According to Riessman (2005), the definition of narratives is contested, with diverse working definitions of narrative analysis that attest to the fact that narratives are cross-disciplinary and draw on diverse epistemologies, theories and methods. There is therefore no clear-cut definition. Narrative analyses in the human sciences belong to a group of approaches used in diverse kinds of texts, having one thing in common - a storied form. These stories relay accounts of the past, while it is argued that narratives are useful in research because narrators create a space to interpret the shifting connections among the past, present and future, because narrators interpret the past rather than reproduce it as it was. However, narratives do not often speak for themselves as they require interpretation. On the other hand, they do offer approaches to the social sciences as regards how knowledge is constructed in everyday life with communicative actions, which are an ordinary everyday occurrence.

A narrative contains and takes account of basic issues of structure, meaning and context. Mischler (1986) defines narratives as transcribed experiences, which the researcher sorts out, reflects upon, enhances and presents in a revised shape to the reader, noting that everything in culture has narrative aspects. When constructed during the writing process, they contain descriptions, understandings and explanations. As the stories embody a specific context, narratives usually express norms, ideas and images which members of a collective share (ibid). Narratives can also be defined as the respondent’s story revolving around consequences of happenings and events whereby the narrator takes the listener into the ‘scenarios’ and recaptures what occurred in order to
clarify a point often of value or moral significance. Narrators tell or narrate a story, which they structure temporally and spatially. Riessman (2005) indicates that respondent narratives involve everyday life experiences; as they look back and recount lives that are located in particular spaces and times, narratives often interpret and provide meaning to the world and lived experiences. While narrative analysis may often attempt to understand the how and why of narrated events, moral values are created on how the ideal should look like. Central in narrative analysis is the reformulation of narratives or stories in varied contexts, while the differential experiences are used to analyse social representations.

I found that both narratives and thematic analyses were analytical strategies that I could use to explore and understand the THs’ perspectives. Narrative analysis pays closer attention to respondent voices. As defined by Riessman (2005):

Narratives as an approach to analysis must be preserved not fractured, by investigators, who must respect respondents’ way of constructing meaning and analyse how it is accomplished (Riessman 2005:5).

This statement refers to respondent experiences and narratives as important and asserts that they should not be fragmented by investigators and researchers; the argument is the story should be preserved as much as possible. I exercised caution in my approach in the interpretation process, as I wished to be transparent about my pre-understanding of the context.

Using a narrative approach to the empirical material has an advantage in that the researcher can focus on the more coherent stories of the respondents, including their feelings, thoughts and experiences as constructed in their narratives. The story in this thesis of an elderly traditional healer (Dani) is an example for introducing my work that illustrates the voices and perceptions of THs in the study area. My use of the respondents’ narratives entailed exploring how they narrated their experiences and then placing short extracts of these narratives into context. I examine and provide topical narratives by the THs related to certain themes (therefore the combination with thematic analysis). I argue that it is still relevant to talk about narrativity, as the way of conversing and relating experiences was within a specific oral tradition, from which I chose citations and
phrases in the form of shorter narrative topics. These topics were related to my research questions and the emerging themes.

Mishler (1986) further argues that when interviews are open, or at least semi-structured, interviewers and respondents pursue a joint venture to construct the narrative. Strauss et al. mention that narratives do not speak for themselves or have unanalysed merit (Strauss and Corbin 1998), but rather require interpretation when used as data in social research. Strauss and Corbin define this as:

The most taxing questions that qualitative researchers face tend to concern not how to gather data - the techniques of interviewing, observation, tape and video recording, generating personal histories and accessing records and other documentary materials are very well known and easily learned - but rather what to do with such data when you have it (Strauss and Corbin 1998:11).

Riessman (2005) argues that using narratives is useful in research precisely for what they illuminate and interpret about societal aspects in the story of the narrator. Narrative analysis may thus forge connections between personal biography and social structure – the personal and the political (ibid). Lawler (2002) presents narratives as stories and accounts that contain transformations which bring together images connecting past and present, self and others; and though they may be characteristically fragmented, narratives can still clarify a great deal concerning societal phenomena in the place where the respondent resides, as well as personal issues.

The other reason I opted to choose narrative analysis is the character of my empirical material. Most of the respondents used proverbs, metaphors, gestures and ‘sayings’ in their descriptions of events and events in their communities. Their deeper meanings could be better captured through narrative analysis than through GT.

The form of communication within the TMK system is part of an oral tradition, with the role of oral pedagogy central to its transmission and practice, as documented in research (see e.g. Mirambo 1999 and Hammersmith 2007). The form of oral tradition among the Luo and Sukuma relies heavily on tacit
knowledge, and I found many of symbolic, conceptual terms and messages that the THs use to express TMK cultural and various societal issues including human behaviour; in narrative forms, this would not be easy to put into exact words. Some of these included beliefs, perceptions that they had acquired when learning TMK and now use in their work in transmitting TMK to apprentices as well as in relation to societal factors and their profession. As Battiste (2000) notes, indigenous knowledge is transferred to subsequent generations through modelling, practice and animation, while heavily relying on tacit knowledge. Oral pedagogy among the Sukuma, for instance, often teaches, entertains, warns, prays, instructs and expresses the mind of the people (see e.g. Mirambo 1999:4). I therefore resolved to examine the THs’ ‘minds’ through the various expressions I could identify within the narratives that could aid in developing the analysis, forming patterns and themes within the transcribed data.

As we will see in Chapter 8, oral traditions and their transmission rely heavily on memory and good receptiveness as well as the keeping of secrets, while demanding ethical and moral responsibility of the apprentices as well as the TH in learning and practising TMK.

4.2.2 Thematic analysis

Thematic analysis is viewed as a main pathway of qualitative methods, due to its path of common approaches with a number of qualitative methods in the social sciences. I use thematic analysis to extract themes from my interview data (Boyatzis 1998). During my translation/transcribing exercise (from Dholuo23, Kiswahili and Kisukuma24 into English) and later, reading through the translated and transcribed interviews, I identified important themes and subthemes from the interviews. Braun and Clarke (2006) describe thematic analysis as a method not based on a specific or pre-existing theoretical framework, but rather one used to identify, analyse and report themes found that are closely related to the empirical data. One advantage of this approach is its flexibility and sensitivity to emerging themes in the empirical data. It permits an accessible and flexible

23 Dholuo-Language spoken by Luo ethnic society.
24 Kisukuma-Language spoken by Sukuma ethnic society
approach in terms of theoretical perspectives in analysing qualitative data. Thematic analysis can be used in an approach influenced by a theoretical pragmatic drive to find emerging themes related to the study’s research questions. It may thus be used to identify and analyse patterns (themes) within data, which aids in organizing and describing the data, while facilitating its interpretation (Boyatzis, 1998). In this study thematic analysis describes an analytical approach to the empirical material as a response to the questions and aims of the study, as outlined in the introductory section of this thesis. The themes thus identified were closely linked to the empirical/interview material (Braun & Clarke 2006).

The choice to use a thematic narrative analysis approach in the analysis of my empirical material permitted me to reach a more profound understanding of the phenomena embedded in TMK and related practices, as perceived by THs and other respondents. I found it useful to try to find common thematic elements across the narratives and stories represented in the texts transcribed from the interviews and the events they reported.

4.2.3 Thematic narrative analysis

Oral narratives are a way of expressing meanings and experiences, for instance in situations of changing social situations. In this study I draw examples from interviews conducted within a context of dynamic changes in social spatial dimensions in the Eastern Lake Victoria Region. In their stories, the respondents’ oral narratives describe their experiences with regard to how societal and spatial dynamics are influencing their TH profession. Their narratives have varied, indicating variations and differences in relation to gender, age, and whether they are rural- or urban-based.

One way people construct and express meaning to make sense of their experiences is through telling stories or narratives (Mishler 1986). A narrative is important because it speaks about both an event and how it was perceived by the narrator (Helgesson 2006).

Narrative analysis is a tool for geographers that can aid in linking meanings in interviews to wider socio-spatial transformations. Through stories and oral
narratives, people construct and translate their everyday life experiences, which can relate their experiences to and provide an understanding of societal processes that engage them in their space and place.

“A thematic narrative approach focuses on themes within a story to give narratives a sense of direction and purpose, with an emphasis on the ‘told’ generally without attending to language, form or interaction”. (Sandberg 2011:46). Using a thematic narrative analysis framework can enable a closer understanding of how oral narratives are understood within a context of social spatial processes and their effects on lived experiences.

In this study I use a form of thematic narrative analysis to examine the content of the respondents’ oral narratives. I use this approach to bring to the surface information that is embedded in, and can be obtained from, the narratives. The focus was on the content of the stories and recurrent narrative patterns in the interviews (see also Sandberg 2011).

As I worked through the transcribed stories and narratives, I identified both similarities and differences within them as emerging themes evolving throughout the analysis.

A contextual analytical approach which entails the interpretation of stories is discussed in scholarship by Wiles et al. (2005). I applied a contextual interpretation of the narratives in the analytical approach, since my aim was to develop themes from the stories and narratives. In order to understand the themes and for them to have meaning, I needed to put the issues and understandings into context. This approach explores common themes in the narratives. I therefore engaged with the context of the stories, while identifying themes and societal processes in the respondent narratives. Polkinghorne’s (1995) analytical approach to narratives engages similar themes in different respondent stories and narratives, while the focus is on the story/narrative rather than its structure.

My study addresses some of the various themes identified in the analysis of the transcribed material: the inter-generational learning and transmission of TMK;
the commercialization and commodification of TMK; and the formal and informal organizational governance of TMK.

Some disadvantages of analysing narratives through a thematic approach can arise when a number of narratives are placed into similar thematic groups. According to Riessman (2008), this could cause the misperception and misinterpretation that all narrators have similar meanings in their stories. This analytical approach, however, allows the narratives’ and stories’ contents to emerge, while paying less attention to their structure. Citing similar thematic patterns within the different narratives while retaining the stories, their contexts and flows is an advantage offered by this approach.

4.3 Conducting fieldwork

4.3.1 Access to the field

Research for this study was conducted in two areas, Nyanza in Kenya and Mwanza in Tanzania (see Chapter 5). I chose these two areas for two reasons. As I discuss in Chapters 1 and 5, these areas are situated in the peripheral regions of the respective countries, which are inhabited by the two largest ethnic societal groups, well known for their knowledge of TMK as well as for their intense migratory traditions embedded in their socio-cultural and socio-economic way of life. Secondly, the peripheral nature of this region has also resulted in some specific socio-spatial changes in these areas in the respective national contexts, which I discuss further in Chapters 5, 6, 7 and 8. The two areas, Nyanza and Mwanza, are situated in the Eastern Lake Victoria Region and are separated by the border between Kenya and Tanzania, which I traversed during my fieldwork. In both areas I conducted fieldwork and interviews with respondents in urban as well as rural village settings, in line with the research questions. The rural settings were important as the areas where TMK and TM are collected and where most of learning practices take place, while the urban settings provide for the commercialization of TMK and practices and is where migrants predominantly move. In both areas I chose smaller towns, where it would be easier to access THs
who are well known in their profession, while in both towns I had links with some organizations that could assist me in identifying potential respondents.

In Tanzania the rural settings were three villages within Magu District and one village within Missungwi District, while the urban setting was Magu Town. In Kenya the urban setting was Homabay Town while the rural settings were seven villages within Homabay District. Key informants from different organizations were interviewed in Dar es Salaam, Tanzania and Nairobi, Kenya. These included TH associations, government institutions, NGOs and academic institutions.

The respondents were practitioners of traditional medicinal knowledge and products, including traditional birth attendants/midwives, THs, diviners, bonesetters and herbalists in rural and urban areas, as well as representatives of TH associations, scientists and practitioners working within research and administration institutions. The sampling was guided by the aim to achieve maximum variation in experiences of THs, and snowball sampling was applied in both contexts. Both men and women of different ages are part of the sample (individual female and male THs, as well as husbands and wives working together). Among the older THs the majority are women, often widowed. The majority of the THs had a primary-level education, while three females and seven males had a secondary formal education. Only two had not been educated in the formal education system. The interviews with the older healers – both male and female – formed the basis of analysing longer-term trends in practices over time, while the younger healers contributed to insight into contemporary issues on TMK, for instance related to the youth in rural and urban spaces. The older THs provided stories of the past as well as the present; many had experiences from being practitioners during both the colonial and post-colonial periods. This provided insight into shifting meanings over time with respect to learning, commercialization, commodification and organizational dynamics. The choice of both female and male healers was intended to provide different gender perspectives on TMK, and the choice of both the Tanzanian and Kenya settings was intended contribute to a better understanding of some national dimensions of TMK as well as the rural and urban settings in Sukumaland-Mwanza, as well as the rural and urban settings in Luoland-Homabay.
The main thrust in this study is not a comparative analysis between the two countries. However, I do discuss some similarities and differences throughout the study, for instance regarding informal and formal organizational structures (Chapter 7), modes of transfer of TMK (Chapter 8) and socio-political dimensions (Chapter 5). Rural and urban based THs also formed the basis for analysing similarities and differences in inter-generational learning systems and the commercialization and commodification of TMK.

In 2005, I spent a total of four months in Tanzania and Kenya in order to prepare for the main fieldwork. Prior to this period, in earlier years I had worked in Dar es Salaam and was thus familiar with projects conducted within relevant ministries, government and NGOs and university departments. I was able to establish contact with these institutions when working in the country. The study does not take a systematic analytical approach to the different discourses of individual institutions and organizations in Tanzania and Kenya. However the material has served to provide contacts with individuals and organizations working with similar research in the country, background information on the study area and the discourse of TMK, gender and youth livelihoods, as well as a deeper knowledge of the policy context within the national and international arenas.

I met, had discussions with and collected documentation from personnel from the following institutions in Tanzania:

- Ministry for Gender, Community Development and Children, Dar es Salaam
- Ministry of Labour, Employment & Youth Development, Dar es Salaam
- Tanzania Gender Networking Programme, an umbrella organization for FEMNET (NGOs working with gender issues)
- The National Environment Management Council, Dar es Salaam
- Institute of Traditional Medicine at the Muhimbili University Teaching Hospital
- The UNDP field office with projects of interest to this study
• The UNESCO field office with programmes on geographical cultural heritage and indigenous knowledge systems

In Tanzania it is the research board Tanzania Commission for Science and Technology (COSTEC) that issues research permits to foreign researchers. I thus visited them to obtain a formal research permit to conduct research in Tanzania. Following my visit to Tanzania I travelled to Kenya with a similar aim of establishing contacts, to introduce myself to relevant bodies and find a field assistant who would eventually work with me during the fieldwork exercise. I travelled to Homabay to meet the district office authorities to seek permission to conduct my research. In Kenya I had a formal letter from my university, which I used as my formal introduction during various sessions throughout my fieldwork exercise in the country.

The contacts continued into early 2006, when I was back in Sweden and taking methodology courses. I established contacts through email and phone conversations with persons I could not meet personally when I was in Kenya and Mwanza. This included a key researcher at the Kenya Medical Research Institute (KEMRI), who in turn referred me to other researchers at the Centre for Traditional Medicine and Drug Research (CTMDR) in Nairobi. Through these contacts I was able to conduct interviews a year later in Nairobi. Other mail contacts were established with:

• Maseno University, Maseno Kenya
• Kenya Forestry Research Institute
• National Museums of Kenya
• Kenyan Resource Centre for Indigenous Knowledge (KENRIK)
• Moringa NGO in Homabay
• Kamuga Women’s Group in Homabay
• SAFINA, an NGO in Mwanza working with THs and with contacts with NGOs in Sweden
• Programme Coordinator of the Nile Basin Initiative in Mwanza
The interviews conducted with the personnel at the university and national research institutions helped me obtain material that I then used to understand the role of research and linkages between research on TMK at the national level and individual THs and TH organizations. It provided a picture of what was ‘going on’ in-country in respect to TMK and TH organizations, including linkages to formal health and education organizations. These contacts also provided material that aided me in understanding the policy framework on TM and ongoing issues in relation to national formal governing structures.

The NGOs and local-based organizations provided material that aided me in understanding linkages between formal and informal health organizations. The SAFINA, Moringa and Kamuga NGOs in Tanzania and Kenya, respectively, which work with numerous THs in their respective programmes, provided both literature through some reports and research they are involved in with communities, as well as an entry point to accessing respondents whom I later interviewed.

The initial period also involved obtaining background information related to the study in the form of literature sources and books, which I obtained when in Tanzania and Kenya during 2005. In sum, the preparatory fieldwork included establishing contacts at research institutions, the university and other organizations working within research fields related to this study in both Kenya and Tanzania. It included assessing available literature and research material in the region within the research field. I also established contacts with grassroots organizations and potential individual respondents to pave the way for the later fieldwork interviews to be conducted.

4.3.2 Field assistants

In both Tanzania and Kenya I worked with field assistants during the first and second fieldworks. Both assistants were male and in their mid-50s, could speak the local language (Dholuo in Nyanza and Kisukuma in Mwanza) and had worked and lived in the area for a long time. In Tanzania I came into contact with the assistant through research contacts, and in Kenya through my relatives. It was
important to work with older persons, as age in this context is an advantage - in this case the delicate nature of accessing potential THs. Male assistants could also assure security during my fieldwork. The field assistants had specific contextual knowledge, which would prove extremely useful during the fieldwork exercise. One disadvantage, however, was that when we interviewed women some respondents would not openly voice their insights with males present. We therefore devised an approach to have three types of FGDs; all female, all male and mixed. The mixed focus group was comprised of older THs, who due to the advantage of age were more at ease in openly discussing perspectives and issues than were relatively younger professionals.

There were many advantages to having older male assistants. Women who do not come from the locality are more accepted in the communities in both the Tanzanian and Kenyan contexts if they “walk around conducting interviews” (as it was termed) with a male counterpart, especially when visiting strangers. The field assistants were very helpful during the snowball sampling we applied; in both finding THs to interview and knowing how to solicit their audience. Most of the healers we interviewed were at their workplace and almost always had a ‘full house’ in their homesteads. Both assistants had worked within programmes involving THs. Mr Chemu in Magu, Tanzania, has worked with more than 50 THs in a programme called SAFINA (a regional NGO active in the Eastern African Region working with issues of HIV/AIDS and the involvement of THs) and is a well-known community leader in this area. Mr Saka, who worked with me in Nyanza, has worked extensively with World Vision, an NGO that works with broad development issues in the area. His deceased father and uncle are well known THs in the area. As already discussed, TMK holders are a difficult professional group to gain access to, but with the help of these two individuals who are anchored in these communities, I was able to do so. I worked with field assistants in Mwanza and Nyanza, but not when I conducted interviews at the institutions in Dar es Salaam and Nairobi.
4.3.3 Being in the field

The main part of the fieldwork was conducted in Mwanza and Nyanza between June and September 2007, with approximately an equal amount of time in both countries, and a follow-up fieldwork was conducted in 2009 for two months. Work at each site started with the researcher and research assistant making schedules for pre-visits to the THs prior to the actual interview. This was mandatory at some of the homesteads, where the field assistants knew that the particular TH or traditional birth attendant was a very busy person with many patients to attend to daily. This was especially the case with urban-based THs. I witnessed this with one of the traditional birth attendants we interviewed in Homabay Town, who had patients constantly come in during our interview, which lasted two hours. So it was important to decide on a time when we would come and conduct the interview.

During the initial fieldwork in Nyanza we went to the sites of Karachuonyo, Kochia, Gem, Kanyada, Mirogi-Ndhiwa, Sindo-Suba and Homabay Town. Prior to the interviews we agreed on specific time appointments with all the THs in Homabay Town, and all the rural-based THs in Gem, Kanyada, but not the older ones who were mostly based at home, e.g. in villages in Karachuonyo, Kochia, Sindo-Suba, Mirogi-Ndhiwa. A schedule of visits by the researcher and research assistant was therefore agreed upon and conducted. The scheduled visits were mainly to urban-based as well as younger THs (approximately 40-55 years old), while the unscheduled visits were to older THs (approximately 65-95 years old). The latter were mainly rural-based, and the field assistant knew they were almost always around the homestead. The above approach was applied in the fieldwork exercise in Kenya.

4.3.4 Fieldwork in Nyanza

In June 2007, I travelled to Homabay to start my fieldwork in Nyanza. I obtained support to conduct my research from the district administration in Homabay, where I introduced my research project to the district agricultural officer at the Homabay district administration office. This was useful because he then
introduced us further to an NGO working with TMK within the area. As earlier mentioned, Mr Saka had worked with World Vision so he was familiar with a number of key persons in the district administration as well as THs whom we could interview. The distances and travel time between the rural-based THs were long in both Tanzania and Kenya. For instance, our journey of about 45 km from Homabay to Suba-Sindo on a non-tarmac road took almost three hours. At the TH’s homestead when the interview was over, we were offered a meal or refreshment in the form of tea or soda, and a prayer was always said at the beginning and end of the interview and meal. This was the case in all interviews in both Nyanza and Mwanza. In Sindo-Suba, for instance, we were offered a meal comprised of chicken stew and cornmeal. The chickens had to be chased, slaughtered and cooked. Local chickens usually take longer to cook, and it would be seen as extremely rude to refuse a meal as we had travelled so far (according to the THs we had travelled from the “northern part of the world” - Sweden).

During this first field trip, we conducted a total of 12 semi-structured interviews with THs in Nyanza (in Karachuonyo, Kochia, Mirogi-Ndhiwa, Sindo-Suba, Gem, Homabay, Kanyada) and four FGDs.

4.3.5 Fieldwork in Mwanza

When I had conducted the interviews in Homabay, I took the bus across the border town of Isebania into Tanzania and to Mwanza. The distance between Homabay and Mwanza is approximately 300 km, and the road is a paved road. In Mwanza I first visited SAFINA and the Vi-Forest offices, and the Nile Basin Initiative (NBI) offices at Capri point. SAFINA assisted me with logistic support, and we initially visited the office of the regional administration to present my proposal and intent to conduct interviews in the region. We later visited the district commissioner (DC) of Magu District and the district development officer of the Miiusungwi district administration in order to present the research project and obtain approval for the research process within the two districts. The DC of Magu had recently been assigned to his assignment post in Magu, and expressed his concern during our meeting on how to address the problem of sorcery. Sorcery, he said, was widespread within Magu District and he was interested in
any initiative that could help them in combating this ill in the communities. At this meeting I was with the field assistant and one of the THs, whom we later interviewed and who was a member of the Mwanza regional health board as a representative of THs in the district.25

In Mwanza I received support from SAFINA in contacting one of their programme leaders, Mr Chemu, who is the director of Huruma Peace Mercy Foundation, an NGO agency that has worked with THs and local communities for a long time. He is also a community leader in the church and well known in the area. He was instrumental in contacting key THs, whom we interviewed, while SAFINA and NBI provided logistic support especially in accessing rural-based THs in Miisungwi and Magu Districts. The distances were further in Tanzania than in Kenya; for instance, it is 75 km between Mondo Village in Miisungwi District and Magu Town. This required a four-hour trip on unpaved country roads, so logistic support was vital in this exercise. We conducted an all-male FGD in Mondo Village. The head of this village, a TH, and the other THs residing there were quite organized as they were used to receiving researchers. Our understanding was that an American research team had visited them the previous year and had promised to assist them with constructing a day-care for the children of the village. When I asked whether we could have female representation in this discussion, I did not receive a clear answer and we were told that they were busy with chores, and it did not appear that broaching the subject further would help. It was clear that gender roles in this village were clearly defined. After the focus group discussion, the women and children came and met us and sang songs in choir form with drums and dancing, and we took pictures after visiting the ritual places. During the FGD, since the discussion was sometimes in Kisukuma, it was not always easy to get clarity on what the THs meant, but Mr Chemu helped clarify most of the discussion on site and later during the translation process. This village helped me observe how rituals are important in TMK and in the work of the healers. The FGD took place in a village setting, and afterwardS we visited two places in the village: one where the THs

25 This TH, whose partner is also a renowned TH in the district, has since been appointed as the Director of the Agricultural Board at the Mwanza regional level. In my recent visit to Tanzania in 2012, we met in Dar es Salaam, and at the time of writing, she was involved in the finalization of the annual regional budget on food and agriculture, which was to be presented by the Mwanza Food and Agricultural Board to Parliament in Dodoma.
perform rituals (See figure 4.1) using agricultural products which are locally available, including indigenous food crops (cow ghee, sorghum, millet); and another which the head of the village referred to as the village’s weather station, a site where they predict good or bad agricultural crop harvest.

Figure 4.1: Photo from Ritual space and place at Mondo village, photo taken by author.

Our initial contacts had been with one of the main interviewees, a well-established TH in the study area who had worked within SAFINA’s programme in Magu. Another TH helped introduce us to the government administration in the district, with which she has constant contact through her work with community development. The former helped us contact THs he knows and has worked with in the district, for instance in Magu Town and in Mwalina Village. Mr Chemu also suggested we meet Forum South, a Swedish umbrella organization for NGOs with its office in Mwanza City. My previous work with UNDP’s Nile Basin initiative enabled me to request support with transportation logistics to some THs in Magu District.

Preliminary introductory visits to the individuals and groups then followed, with the field assistant contacting THs prior to our interview. For instance, before an interview with THs, we first met them at their homestead and made an appointment for the interview, for instance two days later. We conducted three interviews, in villages in Magu District and Misungwi District, and in Magu Town. In Magu and Miisungwi we conducted two FGDs.
4.3.6 Reflections on the fieldwork

When I had completed the first two field visits in Mwanza and Nyanza, I noted that the fieldwork in Nyanza was easier than in Mwanza. My native town is Homabay, and as mentioned earlier I speak Dholuo and though I do not live there, I was not considered an outsider. I am an insider in the context of Kenya, however, but at the same time an outsider in the local context. I looked for ways to develop a cordial environment and a sense of informality with the interviewees. Griffith (1998) points out how a researcher can be like and also unlike his/her research informants, bringing out complex ways in which researchers have to negotiate insider-outsider identifications. This scholarship provides examples of issues related to insider-outsider research and discusses the dilemmas that may arise that are not always straightforward, for instance the position of the researcher as ‘insider’ or ‘outsider’ to the community being researched and whether or not the community already has a voice (ibid: 126). He argues that:

Relative insiders have to face the charge that they are distanced from the community which they have researched: that they might have become empowered themselves, and found a voice, but that this should not be confused with the voice of other people in that community (Griffith 1998:139).

However, the THs were open and eager to share their knowledge with us. There was sometimes a disadvantage, as the interviews were often interrupted by patients who wished to talk to the THs or the assistant. At the interview with one TH in Homabay Town, the field assistant had to leave the interview and take a phone call outside the room, which took some 20 minutes. Such interruptions were more common in the interviews and discussions in Nyanza.

After the interviews in Mwanza, I took a plane to Nairobi and met with representatives at the following institutions: KENRIK, KEMRI, National Museums of Kenya, and the University of Maseno. It was during this time that I had teaching sessions at the Department of Geography at the University of Dar es Salaam and presented my research proposal at a seminar at the department. In Nairobi I conducted interviews with two organizations (KENRIK and KEMRI) and had informal discussions with four institutions (National Museums of Kenya,
the UNESCO field office, a representative of Maseno University, and a representative of Moringa NGO). Thus, during the first field trip I conducted 12 interviews and four FGDs in Kenya and five interviews and two FGDs in Tanzania, a total of 17 interviews and six FGDs.

4.3.7 The second fieldwork

In June to August 2009, I performed follow-up fieldwork in Nyanza and Mwanza. After visiting Homabay, where I did not conduct any field interviews but went to Dani’s grave (who had passed away 5 months after the interview mentioned in the preface), I met the field assistant and had discussions with the coordinator of the Moringa NGO. I took a bus at Rongo trading centre at 3.30 am, a bus that travels from Nairobi to Mwanza and passes Rongo trading centre (situated an hour outside Homabay Town on the main Nairobi-Tanzania (Isebania) road). I left Homabay for Rongo with my mother at 10 pm and waited at a hotel next to the bus stop at Rongo. I was in constant contact with the bus coming from Nairobi that would stop and pick me up at Rongo trading centre. At 12 am, (midnight) which was the scheduled time of arrival, I was still waiting and sitting on the veranda of the hotel with the watchman listening to Congolese music while the last bars had closed...and the curious watchman who I was waiting with asked me politely My sister what is it that you work with? Clearly, meeting a female individual, alone at night with a box and a laptop, waiting to catch a bus coming from Nairobi at that time of the night was not a frequent occurrence (I perceived this in his tone). At 3.30 am the bus arrived, and I continued my journey into Tanzania, reaching the border town of Isebania at dawn.

Mr Chemu met me in Mwanza, and during this fieldwork visit I visited the district development officer in Magu Town to further present my research intent and update the office on our previous visit. This was also the case with the district development officer in Miisungwi District. During this visit we had one FGD session with a youth group from HUPEMEF and met another youth group from Makongoro who were based in Mwanza. The participants in this youth group were very open in their discussions on issues affecting their livelihoods, including unemployment and the lack of opportunities to access the labour market. We also
discussed how the pandemic HIV/AIDS has affected the youth disproportionately and how they have worked with THs to help them mitigate the rapid increase in incidence and prevalence among the youth. Unfortunately the gender balance in this group was skewed, with only three female participants among 12 males. I was therefore always conscious of this and reemphasized during the discussions that we needed to hear what the girls had to say, as I saw they were shy to talk. This forum gave me an opportunity to discuss and access the youth perspectives related to livelihoods, HIV/AIDS and socio-spatial changes in this area of study. Unfortunately I did not have an opportunity to have a similar group in Nyanza with youth perspectives, but I resolved this by meeting the women’s group in Kochia, who work predominantly with youth in their programme. I was able to get the youth perspectives in this setting from the FGD there, as well as with some THs who work in Homabay Town.

No interviews were conducted with THs during this visit. I had discussions with representatives of the Red Cross, the Red Cross school for medical practitioners, the youth clubs at two secondary schools and HUPEMEF, all located in Magu District. The Red Cross school for medical practitioners trained individuals to provide health care in communities, and I was informed of the work they do in collaboration with THs in communities in Mwanza Region. Through SAFINA I received a contact to an entrepreneur in Mwanza City who works with alternative health products and whose mother I visited at her home. A retired worker, she further provided me with a contact to a farm where TM and herbal medicine are cultivated outside Mwanza City. I visited the Bunda Moringa and Artemisia farm facility in Bunda Town (in both 2007 and 2009), which is situated at the boundary between Mwanza and Musoma Region about 180 km by bus from Mwanza City. We took the coordinator’s motorbike and travelled to the farm with the coordinator, passing farmland and homesteads.

We also visited some of the farmers involved in cultivating, for instance, Artemisia (see Chapter 8 and 9). One farmer in this area lamented how the rains that year had not been consistent as in previous years and that the crop was not as good. At this site I had the opportunity to discuss and observe how selected TM products are cultivated and sold commercially, both locally and abroad. Some
challenges and opportunities for the commercialization of TMK were discussed, as well as how efforts to resist the socio-cultural challenges due to societal changes such as the HIV/AIDS pandemic can be supported through TMK and its commercialization. The farm is a joint German-Tanzanian initiative. The person responsible was once a pastor in the community and had a wide network in this area, and was thus active in supporting patients who still went to his previous workplace and who came to seek knowledge on TM products that could assist them (we frequently joked with him about how he was previously a ‘curer of souls’ and now he is a ‘curer of bodies’). The coordinator of the project was working with counselling support for some groups of people living with HIV/AIDS who purchased products from the shop of the farm located in Bunda Town, which he was running together with his wife.

4.3.8 Participant observations

In Mwanza Magu I visited two key THs I had interviewed earlier, and participated in two observation sessions. I used participation observation sessions to gain an understanding of circumstances in the villages and, as discussed above, commercial aspects of TMK. Participant observational field studies took place in Magu, where I stayed for a longer time and observed how THs conducted healing ceremonies with a number of their patients. This was performed mainly at night but also during late afternoon, and involved various activities during which the apprentices training to become THs were involved. I observed TH activities, including travelling with the apprentices who were ‘sent’ to harvest TM products. The time I had at my disposal allowed me to be present for a week, during which a beneficiary who had come to access services for an ailment was treated. I resided in the homestead of the TH in the village outside Magu Town during this period and observed activities including healing activities both during the day and at night, as well as prayer sessions for some patients and the preparation of some TM products, and visited the ‘pharmacy’ of the TH, which is situated in two rooms in the homestead. (I had earlier been able to observe the ‘pharmacy’ for all the THs interviewed in Magu and Rachuonyo, and to view and ask questions about the TM products and the TM product collection
with the TH organization based in Homabay and at the markets in the case of Nyanza.)

During one of the healing ceremonies, I walked with the TH and beneficiary to an open field at 1 am and observed the process and steps used to cleanse the beneficiary. This included the sacrifice of a goat (during the previous day we had accompanied the TH to the market to purchase the animal at the goat market outside Mwanza), while the apprentice was present and actively involved in obtaining what was needed, e.g. warm clothes, water etc. Here I saw the aspect of ‘being sent’ as a form of learning TMK, which I further discuss in Chapter 8. On one occasion during a healing ceremony, I witnessed this aspect conducted at 1 am, involving a young beneficiary. Part of the activity entailed the TH, the beneficiary, the apprentice and myself walking to a field about a half a kilometre away from the homestead of the TH. It involved a healing ceremony in which the beneficiary was washed with water containing herbs, and it was conducted in an open field among farms. This experience gave me deeper insight into how THs work and provided more perspective than the interviews had done.

I conducted other participant observations in the marketplace outside Magu Town as well as in Homabay and Rodi Kopany, a junction town between Mirogi-Ndhiwa and Homabay one traverses on the way from Mirogi to Homabay. This provided an opportunity to observe the situation related to the increased domestication and cultivation of TM plants due to decreasing populations of wild plant species, which in turn is due to increased populations and land scarcity. This is discussed further in Chapters 7 and 8.

I was present in Homabay and Rodi Kopany markets during the main market days on two occasions at each market, the first market with the THs from the TH organization and the second market with the TH from Gem. At all three observation sessions mentioned above, I could observe the situation related to commercialization of TMK and TM products, which is on the increase in both Nyanza and Mwanza. I observed how the THs sold and advised, while noting how the products were used in relation to the patients'/customers' needs, and how they were attending to them. I had the opportunity to observe how the dynamics
of the trade take place. One TH who both works in the rural area and comes to the market on market days was able to discuss with us how he carries TM products to the market on market day and divides his time and occupation between the two settings. We also visited two village hospitals in Magu, where we observed how the TM products are processed (including drying and grounding) and stored. We also saw how the spouse of the female TH, the latter of whom was the main TH of the village hospital, was developing the patients’ accommodation. One of the village hospitals was situated near the main Mwanza-Kenya road, and patients resided with their relatives (who stay with them throughout the time they receive help from the TH until they return to their homes) in huts spread throughout the locality of the hospital. Village hospitals were a feature in Mwanza more often than in Nyanza, which I further discuss in Chapter 8.

Figure 4.2: Photo of section of a village hospital- Magu Mwanza, photo taken by author.

I also conducted another participant observation, which I term a plant walk. In Rachuonyo we walked with the TH and observed different traditional medicinal products, obtained from different regions of Kenya where the TH had worked and planted in the homestead. The older TH wished to identify the plants she had planted over a period of time, and identified more plant species within her homestead as well as those growing wild, all of which she used for various medicinal purposes. She further explained to us how she imported some of the
TM products from other regions in Kenya, where she had lived under extended periods. Here I was able to observe a situation of a TH activity related to commercialization and conservation, which are claimed to be a threat and a strategy, respectively, for TMK.

During this second field trip I travelled to Dar es Salam by bus from Mwanza. Once there I met with a representative of the National Environment Management Council (NEMC) of Tanzania, who was also planning to conduct research with THs in the spring of the following year in Mwanza. Other meetings I had were with the representatives at the Ministry of Gender, Community Development and Children; Ministry of Labour Employment and Youth Development; Tanzania Gender Networking Programme (TGNP); the UNESCO field office and the UNDP Global Environmental Facility (GEF) small grants programme.

En route back to Kenya by bus I stopped over in Arusha Town, Kilimanjaro, where I interviewed an urban-based TH in Arusha Town, whose contact I had obtained from a colleague at the Geography Department at the University of Dar es Salaam. Thus, during the second field trip I conducted three participant observations, one institutional interview, one FGD and one interview with an urban-based TH.

4.4 Conducting the interviews

There were no significant problems involved with conducting the interviews, apart from the long distances, except in one case in Mwanza City when an urban-based TH turned us away and refused to be interviewed. His argument was that he did not understand our intentions and was not willing to share his perspectives with ‘unknown’ sources.

Semi-structures interviews with both closed- and open-ended questions were used. Traditional medicinal knowledge and uses of local/non-local products, learning practices, product characteristics, dispositions and marketing characteristics, societal processes involving migration and institutional aspects of TMK formed the main focus of the questions. The choice of open-ended and
closed-ended questions was deliberate, to give an opportunity and space for the THs’ narratives and life histories, which from previous experience I realized would be frequent. This later proved to be a good way to obtain rich information as well as collect the opinions of respondents in a participatory way. The same interview guides were used for men and women, and some questions were related to the division of labour in daily tasks and responsibilities between women and men. Women and men were interviewed separately as well as together.

The semi-structured interviews, which lasted approximately 60 to 90 minutes, were based on general aspects of the interviewees’ daily life in relation to TMK. In both study areas we asked about cultivated medicinal plants and traditional wild harvesting, gathering practices and changes occurring within the locality related to migration and urbanization, how they practised TMK and their perspectives on how they were perceived by the communities where they practised. The interviewees’ personal data, such as gender, age, education and family, were gathered as well. Also of interest were aspects related to TMK learning processes, at what age and how they received TMK, how it was learnt and who they had learnt from, and how they themselves taught their knowledge to others. I also asked about their views on the youth’s interest in learning and future prospects for traditional medicinal knowledge and practices.

Issues regarding collection, methodology and tools for the fieldwork were closely discussed and analysed prior to conducting data collection fieldwork. A notebook, tape recorder and camera were used to preserve the interview statements and pictorial evidence. Throughout the fieldwork we were careful to establish ethical consent with respondents, and considered it important to clarify why we wanted to interview them. Mr Saka and Mr Chemu almost always made this clarification in the local language for clarity in context. This was sometimes the case with the older THs, who could use complex language terms or metaphors to explain themselves that were more difficult to directly translate. The fact that I am from Nyanza and have older family members who are well known in the study area facilitated access and permitted us to use a snowball sampling technique to locate THs in both Mwanza and Nyanza.
Interviews were taped and conducted in Kiswahili and Kisukuma in Mwanza, and in English and Dholuo in Nyanza, while all interviews in Dar es Salaam and Nairobi were in English. In Nyanza almost all the interviews with THs were conducted in Dholuo, except for two in English; one of which was with the chairman of the organization of THs in Homabay. None of the interviews here were conducted in Kiswahili, which is the national language in Kenya. This is because in Nyanza, Dholuo, the local language followed by English, is the preferred language of communication over Kiswahili, even in the local communities.

In Mwanza we conducted all of the interviews with THs in Kiswahili, which is the national language of Tanzania. However, in some cases the discussion would ‘spill over’ into Kisukuma, especially when we had FGDs or when the interviewee was an older TH and wanted to describe and clarify something further. In the latter case, the field assistant later helped me translate the taped discussion into Kiswahili, which I then translated into English before transcribing the text. Also, some of the older THs in Nyanza used some older language terms in Dholuo which I needed clarification on. I asked the field assistant to clarify for me on site with the TH, or later during the translation process. This was also the case in Kiswahili in Mwanza, where some terms would need clarification by the field assistant.

I mainly worked with the field assistants in the Homabay area and Mwanza, but chose not to work with them when conducting interviews at the research and university institutes in Dar es Salaam and Nairobi, where I felt I could work alone as I have previous experience working in some of the institutions in this region. The two field assistants contributed a great deal to the success of the fieldwork. They helped identify respondents, explain our purpose clearly and make the respondents comfortable. They aided in the interpretations throughout the field period. Sometimes disagreement would arise between me and the field assistant in Kenya, who speaks Dholuo. Due to his position in the prevailing socio-cultural context would engage me in discussions on his ‘leading the team’. This would involve, for instance, his wanting to ask questions not directly relevant to the study, thus diverting and elongating the interview session and content. His
explanation, which he based on the oral nature of the narratives, meant that they could go on for a long time. However, I would guide the discussion with him, for instance explaining my ‘insider/outsider’ dilemma to him and telling him he could view his position as not only guiding the fieldwork undertaking, but also assisting me mainly in making interview spaces comfortable for the interview sessions and providing the much needed justification and clarification to the THs why they should share the TMK information with us. The views of the field assistant in Mwanza were particularly important, as some of the respondents - as I mentioned earlier - would talk in Kiswahili and then, particularly in the FGD, ‘migrate’ into Kisukuma. In these cases it was particularly important that after such interviews (as was the case with the others) we sit down and discuss the interview, and that I write down clarifications that he provided on what had been discussed, both in another language as well as what was meant by certain non-verbal communication, metaphors and proverbs.

The field assistants and I continuously discussed important points from the interviews, which aided us (and me in particular) in the interpretation and analysis of the interviews. The THs (particularly the older ones) used older language that I was sometimes not familiar with, even though I speak Dholuo and Kiswahili, so I needed clarification from the TH and the field assistant. I placed importance on understanding the perceptions of the TH as they expressed it themselves, and therefore when they made gestures and used body language that I could not record, I made notes on this. I therefore asked for clarification from the TH, but I would also have discussions with the field assistants on the meanings later, based on the taped versions. As mentioned earlier, THs are not readily willing to share their knowledge and perceptions with ‘outsiders’, so usually when I needed clarification on interpretations I asked the field assistants for this.

The field assistant in Kenya spoke the same mother tongue as I do, and we would sometimes disagree on meanings due to the nature of the work. Since his father had been a TH, I would mostly ask him to explain further as I trusted his interpretation based on his background.
The interviews and discussions with the organizationally based informants, such as TH associations and researchers, took place at the respective institutions. In Homabay we talked to the TH organization, which is most active in the town area. Most members are urban-based, and most were male (with only two females). All were active as THs in the different forms as described earlier: bonesetters, herbalists, diviners, traditional birth attendants. At the TH organization in Mwanza, the committee members were interviewed.

In Nairobi and Dar es Salaam, the research institutions and organizations I visited had representatives whom I talked to and who explained that they had contacts and active involvement with either individual THs or TH organizations within the country and the region. Regional organizations of THs (for instance in the Meru District of Kenya) were already in existence, coordinated by a programme at one of the institutions in Kenya, for instance the East African Network for Traditional Medicine housed at the Centre for Traditional Medicinal Research (CTMDR-KEMRI) in Nairobi.

The interviews with the THs at the organizations lasted about one to two hours and in some cases three to four hours. In some cases, in order to get additional information FGDs were conducted with persons already interviewed. The majority of THs we met were in the age group of 45-90+ years, while some were in the group of 35-45 years (the latter are considered young THs). Here, age was not discussed in precise numbers. Within the local context, most respondents defined their age in terms of events and events that had taken place in the region or the stage in life in which they found themselves, e.g. a grandmother, father, youth who completes school, aunt etc. One TH, for instance, mentioned that he was a teenager when independence had been declared in Tanzania (1961), which could approximate his age at roughly 60-75 years (interview material). Within the Luo culture, the ritual approach to child naming is with respect to the period and time of day they are born, or through naming ceremonies following the death of an elderly relative after whom the child is then named. For instance, for children born during the rainy season a male is named Okoth and a female Akoth, while for those born during a year when there is persistent drought and thus a poor

26 Koth means ’rain’ in Dholuo.
harvest a male is named Oketch and a female Aketch. If born at dawn (any time between 7 am and 12 pm), a female is named Akinyi and a male Okinyi. The age perceptions therefore revolve around temporal events, with age being an approximation rather than an absolute figure. Generational affiliation seemed more significant than actual age (interview material).

A question guide containing open questions was used during the FGD sessions, which lasted one to three hours. One of the FGDs took place in the marketplace in Homabay, where the TM products are exchanged with patients; this provided a space and place to observe the commercialization of TMK and products as well as the dynamics between THs and patients. The THs in this group in Homabay were sceptical about the group discussion, mentioning that they were not sure how this discussion would change their situation or what we wanted from them. As discussed later in Chapter 7, they mentioned that researchers come over the years and “take their knowledge” and do not come back to give them feedback. They also lamented that the government authorities “do not care” about their work, even though they support communities and even government workers by treating them. A rural-based male TH in Gem also mentioned this. When we asked him if he receives help from the government he said he did not, but emphasized that he helps the government authorities through the services he renders to communities by curing people who were drunkards and “useless to the government work”.

It was an advantage that we had interviewed the chairman of the TH association a day prior to the FGD. Together with him, we had to talk with, encourage and convince the group of THs that I would return and inform them of the outcome of our discussions. The field assistant also talked to them and informed them, citing ongoing initiatives in the region that want to bring together TH associations at meetings like seminars in order to work with them in communities. After some time, we were able to conduct the FGD. Some individually interviewed THs did not believe in organizations where THs are encouraged to work together, though he did not explain in depth why he was personally against this.

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27 Kech means ‘hunger’ in Dholuo.
28 Go Kinyi means ‘morning’ in Dholuo.
The average size of an FGD was three to six persons, while two of the FGDs had more than 15 participants. A major strength of small group interviews facilitated by researchers is that they enable discussion among participants, in this case about differences in traditional medicinal plant knowledge (see Kassam et al. 2010). Although small group interviews provided substantial information, the approach was limited by several methodological constraints: 1) in mixed groups with both men and women, respondents appeared hesitant to provide gender-specific TM knowledge when they were interviewed together 2) some respondents may have dominated small group interactions.

An adaptive interview process can be useful if used to overcome the constraints noted above (Kassam et al. 2010). To complement small group interviews, individual interviews included similar questions adapted from the group interviews, while entirely female/male groups were also convened. Responses provided additional insight because 1) participants provided gender-specific knowledge, 2) the heterogeneity of knowledge among individuals was no longer silenced by group dynamics, and 3) some of the interviews were conducted outside to identify and discuss TMK in situ (for instance the plant walk conducted in Karachuonyo). Thus, having separate female and male discussion groups brought out differences and similarities in perceptions of TMK, which enriched the empirical material. Throughout interviews, FGDs and participant observa-
tions, aspects of respondents’ reactions, body language and gestures were noted in the notebook. This was important for me in my later analytic work, when referring to tacit knowledge and how respondents expressed themselves and perceived phenomena in this field study.

The table below provides a summary of the number of interviews, FGDs and participant observations carried out during the fieldwork in 2007 and 2009.

<table>
<thead>
<tr>
<th>Interview method</th>
<th>Male</th>
<th>Female</th>
<th>Male and Female</th>
<th>Total Number</th>
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<tbody>
<tr>
<td><strong>Focus group discussions (FGDs)</strong></td>
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<td></td>
</tr>
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<td>0</td>
<td>2</td>
<td></td>
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<tr>
<td>Rural</td>
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<td>1</td>
<td>3</td>
<td></td>
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<tr>
<td>Total</td>
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<td>1</td>
<td>5</td>
<td>7</td>
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<tr>
<td><strong>Semi-Structured Interviews (SSIs)</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Rural</td>
<td>5</td>
<td>8</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Urban and Rural</td>
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<td>0</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>9</td>
<td></td>
<td>20</td>
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<tr>
<td><strong>Participant Observations (POs)</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Urban</td>
<td></td>
<td></td>
<td>3</td>
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<tr>
<td>Rural</td>
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<td>4</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td><strong>Structured Interviews, mainly IDs (SIs)</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Urban</td>
<td>12</td>
<td>5</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Rural</td>
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<td></td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Total number of interviews, by gender</strong></td>
<td>12</td>
<td>10</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

*ID=Institution Discussion; Urban=active in urban area; Rural=active in rural area; Urban and Rural=active in both urban and rural areas.*
Location & Ages & Gender & M & F & Interview method \\
& & & & & \\
Kenya: & & & & & \\
Kanyada & 60-75 & Male & Female & 3 & 1 & FGD \\
Hbay Market & 35-75 & Male & Female & 15 & 1 & FGD & PO (2) \\
Sindo-Suba & 43-70 & Male & Female & 2 & 3 & FGD \\
Homabay & 35-71 & Female & & 0 & 28 & FGD \\
Gem & 40-60 & Male & Female & 2 & 1 & PO \\
Tanzania: & & & & & \\
Mondo & 40-70 & Male & & 7 & 0 & FGD & PO \\
Magu & 40-50 & Male & Female & 2 & 2 & FGD & PO \\
Magu (rural) & 40-50 & Male & Female & 5 & 1 & FGD & PO (2) \\

Figure 4.4: Summary of interviews, Focus Group Discussions (FGD) and participant observations (PO) carried out during the fieldwork in 2007 and 2009. PO (2)-Participant observations conducted on two occasions.

4.5 The interpretation and writing process

I translated the taped conversations from 2007 and 2009 into English and transcribed the essential parts of the texts. Riessman (2005) views the transcribing exercise as part of the interpretation process while being the preliminary process in analysis. According to Riessman, standards for a “good enough” narrative analysis in research should consider the following questions:

1. Was the work empirical, that is, based on systematic observations?
2. Did analysis attend to sequence and consequence?
3. Was there some attention to language, and were transcriptions made and inspected?
4. Did analysis attend to contexts of production (research relationships, and macro institutional contexts)?
5. Were epistemological and methodological issues treated seriously, that is, viewed critically, seen as decisions to be made, rather than ‘given’ – unacknowledged?

During the transcribing exercise, I was conscious of and carefully considered the notes I had made on proverbial terms, metaphors and body language, which were
commonly used by both male and female respondents and which carried local contextual terms that I was not always familiar with. I discovered that the respondents used the proverbs and metaphors to express their feelings as well as social phenomena and events in the society and daily life.

Some challenges in the transcription exercise entailed local language terms, especially in Mwanza and the Kisukuma language. It was difficult to understand some of the terms due to the use of proverbs and local expressions, even though my assistant had translated them into Kiswahili. I needed to contact the field assistant on several occasions to ask his opinion on what was meant. Secondly, the fact that I had to translate into English from two languages, for one of which I had to translate some extracts from the interviews (with the help of the field assistant) in three steps, Kisukuma-Kiswahili-English. Some narratives were very long, but interesting. The transcription process was a very interesting exercise as it enabled me to attain an in-depth understanding of my empirical material. However, it was an extremely lengthy process, taking several months in 2008 and early 2010.

4.5.1 The interpretation process

After the literature data from the documents as well as the transcribed interview texts were compiled, the analytic strategy performed was a thematic analysis (Boyatzis 1998). In analysing the interview material, including the observational notes, I used thematic analysis to reveal meanings that I came across repeatedly within the material. Examining the narratives, I identified emerging themes and recurring patterns within the data, which helped in grouping, organizing and describing the texts as well as their interpretation. For instance, regarding the research question on the commodification of TMK, the theme of perceptions of giving versus selling emerged. The themes I identified were grouped and rechecked for their reliability in the interview material and the literature documentation (see Braun & Clarke, 2006). I conducted this interpretation exercise while constantly referring to the field notes and my memories of the everyday life, which I captured in photographs and short video clips. Some of the direct quotes were inserted into the text while some were narratives of the second
order - meaning I interpreted the quote and inserted it into the text. The transcripts of the longer narratives took longer to interpret as most of these were stories from the older THs, containing older language phrases, proverbs and metaphors that required deeper translation and definition. I tried to build a complex, holistic picture, analysing words and individual interview phrases that arose in the interviews and FGDs.

The themes identified were related to socio-spatial aspects of TMK related to rural-urban migration, rural-urban linkages, health diffusion, inter-generational learning practices and modes of transmission and the youth, livelihoods and the youth, the commercialization and commodification of TMK, the urban space and TMK as a commodity, and gender similarities and differences in the use and management of TMK.

When I had reached preliminary findings from the research and conceptualized them, I presented them at seminars and conferences, as I further discuss in the next section.

4.6 Feedback and presenting the findings

As I mentioned earlier in the chapter, I see myself as an actor in the process, involved in a study that is mainly qualitative. The qualitative researcher can be seen as a mediator between those who know and those who want to know.

Figure 4.5: Communicating your qualitative research
Source: Notes on communicating your qualitative research ME, 2005.

I see it as important not only to disseminate the findings to the readers of the texts, but also to develop a form of dissemination of the findings including return visits and meetings with key respondents and institutions. Upon reaching the
stage at which I had the concept and framework of the study with the preliminary findings of the research, I had the opportunity to present them at seminars and conferences. Initially I presented them at seminars with colleagues and researchers at the Department of Social and Economic Geography in Sweden, and in Tanzania. In addition, I presented them at two international conferences in Sweden and Canada. The feedback, comments and discussions I received were useful in strengthening the eventual content and structure of the writing as well as the credibility and reliability of my research.

Earlier I discuss the existence of an epistemological divide (an epistemic and ideological conflict) between Western science/biomedicine and traditional knowledge systems, which some scholarship views as having long survived a significant battleground of epistemological resistance (Odora Hoppers 2002:6). The interpretive writings and epistemology of non-indigenous experts (Fatnowna et al. 2002, see also Macedo 1999) on TMK predominates within the epistemic and paradigmatic view on plant life. The methodological approaches in this study are an attempt to participate in an evolving paradigm of alternative epistemological approaches to TMK research.
5. Contextualizing traditional medicinal knowledge in the Eastern Lake Victoria Region

5.1 Introduction

This chapter provides a contextualization of TMK in the Eastern Lake Victoria Region, and a historical background including an overview of urbanization and migration among the Luo and the Sukuma.

5.2 The Eastern Lake Victoria Region and its population

Mwanza in Tanzania and Nyanza in Kenya are located in the Eastern Lake Victoria Region\(^29\). Following the colonial demarcations of Lake Victoria between Kenya, Uganda and Tanzania, three quarters of the lake is situated in Tanzania, mostly within Mwanza Region (PCD/RCO 1997), while a comparatively smaller area of the lake is situated in Kenya, mostly in Nyanza province. The capital city of Mwanza Region, Mwanza City, is a migration and economic centre in this part of Tanzania. Since the 1950s there have been forced migrations in this area from Rwanda and Burundi, and Tanzania is known as the country that has hosted the most refugees in African history\(^30\) Tanzania’s population of 46.22 million is multi-ethnic, with an estimated 140 indigenous ethnic groups (World Bank 2012). The population is predominantly rural, with an urbanization level of 25%\(^31\).

The Sukuma constitute 90% of the population of Mwanza Region and 20% of the population of Tanzania (Mirambo, 1999, PCD/RCO 1997). Traditionally the Sukuma have practised an agro-pastoral way of life, in which cattle rearing has important ecological, social, economic and symbolic significance (Brandström 1990, Madulu 1998). The Sukuma societies have traditionally been associated with high mobility and migrant expansion (Madulu 1998, Sanders 2001). This traditional trait has continued in contemporary periods, with some Sukuma

\(^{29}\) See map of Mwanza and Nyanza and research sites
\(^{30}\) http://www.icglr-org-accessed 25-02-2013
\(^{31}\) http://www.globalis.se/Laender/Tanzania/(show)/indicators- accessed 25-02-2013
groups travelling great distances, including to neighbouring countries, in their quest for, for instance, mining and employment opportunities.

Kenya’s population of 41.61 million is also multi-ethnic, with an estimated 40 indigenous ethnic groups (World Bank 2012). As in Tanzania, the level of urbanization is low, at about 22% of the population. In the Nyanza Region of Kenya, the Luo constitute almost 60% of the population (Ong’an’ga 2003). Similar to the Sukuma the Luo have historically had a profile of high mobility, and both groups have strong traditions of TMK in the region. The Luo have also traditionally had a pastoralist orientation, but today they practise an increasingly sedentary agro-pastoral-based agriculture. Cattle remain a very important symbol and unit of wealth for both groups (Herbich 2002, Francis 1995).

In recent decades most parts of the Eastern Lake Victoria Region have experienced the loss of most of their forest and tree cover through extensive clearing of forests for agricultural activities and timber production (PCD/RCO 1997). This has had an impact on the availability of vegetation and tree cover in general and medicinal plants and non-timber forest products in particular. Research shows that as urbanization proceeds, the use of non-timber forest products has largely influenced land use around urban areas (Nygård 2000). Observed effects are an increased scarcity of some of the products, e.g. medicinal plants and dry wood, leading to a further decrease in the vegetation cover (Abbot and Lowore 1999).

Historically, Lake Victoria has been a source of livelihood for fishing and agricultural communities in Nyanza province. Agricultural products, including tea, sugar cane and other cash crops such as cotton and coffee, are produced in the north-eastern highlands, but the local economy relies mainly on subsistence agriculture, pastoralism, fishing and seasonal trade. In recent decades the overall livelihoods of these societies have been adversely altered by a number of factors, including the increasing eutrophication of the Kenyan part of the lake due to the

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extensive spread of the water hyacinth. This has severely affected the ecology of Lake Victoria, and may further have contributed to reinforcing out-migration of the youth from the province to seek livelihoods in other regions and in the urban centres within and outside this region (Francis 1995).

In the East African Region in general, the role of traditional medicine is changing in the context of increased urbanization, the domestication of plants and commercialization. Traditional livelihoods like animal husbandry, agriculture, hunting and fishing are experiencing changes linked to increased mobility and increased reliance on alternative economic livelihoods (TAS census 2003). The colonial state economies have established export-oriented crop production, which was and is still key in initiating the commoditization of land and associated struggles over its control and use (Bernstein 2000); whether perceived as private property or under legal state colonial codes. The economy increasingly gives rise to processes that undermine locally available non-timber forest products for their medical, cosmetic and even food needs, while at the same time providing new income opportunities (Wollenberg 1998). Both the Sukuma and Luo communities are increasingly interacting with the market economy through the sale of goods and wage labour, primarily in cattle sales, fishing and cash crop farming (Ong’an’ga 2003, PCD/RCO 1997). Such integration into the market economy brings about changes in occupation, preferences, social organization, and health and well-being including nutritional status. According to Beyer (2009), the Luo and the Sukuma are starting to become cultures that place less value on their indigenous knowledge, especially their ethno-botanical and TMK. Under this pressure traditional knowledge of medicinal plants is starting to disappear, with little to take its place (ibid).

The migration of THs from rural to urban centres as a strategy to improve livelihoods is well documented in studies conducted in Dar es Salaam (Swantz 1981), Nairobi (Good and Kimani 1980) and Ethiopia (Wondwossen 2005). In the

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33 Increased eutrophication of the lake and the further spread of the water hyacinth, which blocks fishermen’s access to the waters of the lake, have had disastrous effects on the fishing sector and local fishing activities, which in historical and modern terms have been of paramount economic and social importance in this region, and have been the dominant livelihood in this province for decades (Achieng 2006).

34 Due to the introduction of the Nile Perch into the lake in the 1950s by the British colonial administration, the number of fish species has decreased dramatically from about 500 to a concentration of only three species. The Nile Perch and its disastrous effects on the fishing sector are discussed extensively by Ogutu-Ohwayo (1990).
empirical section, I discuss the role of urbanization in determining the youth’s and THs’ alternative livelihoods, seeking behaviour in the urban and peri-urban areas.

It is assumed that the individuals from villages who migrate have an influence on the traditional institutions and practices. Swantz’s research (1996) argues that among the Zaramo in Tanzania, rituals are not tied to location and space, but she emphasizes the need of a space for interpretation and action so that cultural values can be upheld. People may return to the rural area for rituals, while on other occasions these can be held in town (under trees, in a yard, within the household space). The traditional healer adjusts interpretations; in the village the cause of illness is interpreted as a manifestation of ruptures in social relations between neighbours and kin, while in the city the illness is interpreted in relation to co-workers and neighbours (Swantz 1996).

It is argued that the very survival of these populations has depended on their ecological awareness and adaptation, with much of their traditional knowledge in general and medicinal knowledge in particular. Within both groups, women have predominantly _exogamous_ movements (within the ethnic group) in marriage, which has served to facilitate exchanges between women from different areas while providing for the integration of new elements and renegotiations of TMK between women of different generations (Geissler et al. 2002).

### 5.3 Tanzania and Kenya – a colonial brief

Tanganyika was a German colony beginning in the late nineteenth century and a British colony from 1918. It gained independence from Britain in 1961 after a protracted liberalization struggle by the Tanganyika African National Union, (TANU) formed in the mid-1950s. This was a period when many African countries, including neighbouring Kenya, were involved in liberation struggles and movements to gain independence from colonialists. A union government was formed in 1964, comprising Tanganyika and Zanzibar, to be known as Tanzania.

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35 Tanganyika was the name of the mainland territory before its union in 1964 with Zanzibar.
The Tanzanian post-independence government’s brand of socialism emphasized equality, people’s participation in decision-making, self-reliance and providing basic needs (Swantz et al. 1996). Tanzania developed a political structure with the intention of enabling people from all levels of society to take part in their own governing. Leadership also prevented factionalism based on ethnicity or religious affiliation, while emphasizing national unity focused around the Kiswahili language. One of the consequences of some colonial and post-colonial policies of *ujamaa* (villagization) was that old traditional methods of using and managing non-timber forest products for the sustained use of land were discarded (Kiunsi 1994). Leaving the sacred sites and ancestor cult places was a mental upheaval for the indigenous people, who were used to living in a certain formation (Sitari 1983).

The period of Kenya’s colonial history began with the Berlin Conference in 1885, and by 1920 Britain had gained full political control and officially declared Kenya a British colony. Kenya gained independence in 1963 after a series of struggles and movements, including the famous Mau Mau uprising. KANU (the Kenyan African National Union) was formed in 1960 with the slogan *Uhuru* (freedom). At an early stage there were independence movements along ethnic lines, which could be linked to the divisions created during the colonial administration.

### 5.4 Health and knowledge systems in a historical context

This chapter attempts to examine TMK in a pre-colonial, colonial and post-colonial setting as well as within a context of changing conditions in post-independence and contemporary Kenya and Tanzania. The aim is to broaden the analysis of TMK by examining and discussing some historical processes in the identified communities. The purpose is to point out certain historical factors that may have had an influence in shaping the contemporary discourses on TMK, which are discussed in this thesis. The issues in this chapter link to the research questions and the empirical discussions later in the thesis as discussed with THs. I see this as important in order to gain a better understanding of the evolving processes and contemporary perceptions surrounding TMK and its practices. It could provide a space in reconfiguring the contemporary discourse within the
education, learning and health sectors in the context of changing societal
dynamics, a possible pathway to secure long-term stability in the form of
livelihoods, health and well-being in the communities.

The spread of Christianity in East Africa was intimately linked and in close
alliance with the establishment of medical institutions. Both the introduction of
Western education and Christianity illustrate the contradictions of colonial rule,
and the impossibility of ensuring its effective legitimacy over the colonized
(Bernstein 2000). Missionaries pioneered the medical institution in the study
region, and in the early 1890s when the German colonialists penetrated into the
interior, missionaries from different European countries were already there. The
missionaries numbered 150, in 40 missions spread over the most important and
populous districts of the German colony of Tanganyika in the making (Koponen
1994). Although the medical missionary institution was ill equipped to deal with
the social reality of 20th-century East Africa (Vaughan 2004), it later became
active in preventative health programmes in the colony and worked closely with
the colonial state health institution when it had been established.

The colonial state health institution relied heavily on the medical missionary
institution due to its pioneering presence and longer experience among the
communities (ibid). Christianity was a central element of the global Western
imperialism’s ideology of its “civilizing mission”, and missionaries often
functioned as informal agents of the colonial state (Bernstein 2000). The
incorporation of missionaries into the colonial state set in motion what are
termed “local compromises” between traditional African leaders, the government
and the missions (Koponen 1994). Patrimonial36 chiefs, if non-existent, were
created by the colonial power and were then supervised by the colonial project.
Missionaries thus provided the initial institution of the health care sector in the
pre-colonial era in Tanzania and Kenya37, and well into the 1950s and 1960s,
while most of those who were trained in tropical medicine in metropolitan Britain

36 Patrimonial authority, according to Max Weber’s definition of a type of authority in small and traditional polities, is characterized
by a ruler ensuring political stability through selective favours and benefits to loyalists who are not citizens of the polity – See Potter

37 An extensive discussion on how missionaries pioneered the establishment of rural hospitals and clinics, trained African personnel,
introduced ‘Western’ midwifery and child care practices, as well as dealing with chronic and endemic diseases, is presented by
were part of missionary institutions (Johnston 2010). This is a reflection of the situation today in the study area, where the bulk of the introduced rural health care model is still provided by missionary bodies and non-governmental organizations (Potter et al 2004). Thus:

Missionaries had been the first to take up medical work in pre-colonial times and the first to open a clinic in Dar es Salaam for Europeans; while an Indian Magnate Sewa Haji provided funds for building a hospital in Dar es Salaam for ‘natives, including Indians, Arabs, Swahili and the like’ (Koponen 1994:462).

Though missionary medical work included a combination of bringing the Christian religion to the region and providing modern medicine and education (training of assistants and nurses), their medical work (as is the case today) should not be understood simply as a tool for conversion. Johnston argues that while conversion was the ultimate goal, medical and surgical care was provided regardless of a patient’s willingness to embrace Christianity (Johnston 2010). However, the predominant approaches of missionary medicine travelled along attempts to create forms of subjectivities through its practice, with a consistency in approaches by medical missionaries to effect more than a physical transformation in their patients through healing (Vaughan 2004). According to Vaughan:

Mission medicine demanded a belief in both the scientific and the supernatural. For many African communities, this was not a totally strange idea, as their own medical systems incorporated both the herbalist and the spirit medium, but early patients were more keen on the immediate benefits of mission medicine than they were on the theological theories of healing which went with them (Vaughan 2004: 60).

This discussion may imply that there seemed to be a consistent emphasis by the missionary institution on conversion to alternative beliefs and opinions. Healing, for medical missionaries, seemed to be “part of a programme of social and moral engineering through which the communities would be saved” (Vaughan 2004:74). As Vaughan further discusses:

Reports in the Church Missionary Society Journal, *Mercy and Truth* for instance quoted: ‘When medicine failed (and despite the success stories, failure was extremely common in this early period of tropical medicine), souls had still been won’ (Vaughan 2004: 60).
In other words, the medical mission’s view was that the advancement of Christian morality, a sanitized modernity and ‘family life’ was the only way to conquer disease and resolve the prevailing health challenges in this region; therefore, Christian notions of the family were preferably promoted rather than reinforcing traditional kinship ideologies (Vaughan 2004:55). Traditional ideologies on ‘public health’ with social dimensions were not encouraged. For instance, African women in the communities welcomed the interventions of maternal and child health campaigns of the time, though the interventions were incorporated into an ideology which represented women primarily as reproducers, which seemed to undervalue their productive role and exalted ‘domestication’ (Vaughan 2004). In essence, there seems to have been a neglect of the women’s knowledge of social health and well-being, as discussed by Carter (1996) and Vaughan (2004).

In agricultural and pastoral societies such as the Sukuma and Luo, the traditional political leaders carried the ultimate responsibility for the communities and the land, including control of witchcraft as a negative application of TMK (a subject I discuss more closely in the empirical chapter later). The fear of witchcraft or of witchcraft accusations was a potent force for social control in local communities (Bujra 2000). The powers vested in, for instance, the chiefs in Sukumaland were over the traditional medicinal rituals and as custodians of the land (Koponen 1988, Brandström 1990). The ritual control of land was in the hands of political leaders and the chief was the overall custodian of TMK, which suggests that the THs and traditional leaders were effectively more in control of prevailing social conditions and health systems during the pre-colonial and early societies than they are today. In my empirical material, THs discuss their working (or non-working) relationships with the formal medical institution as well as their perceptions of their evolving role in prevailing contemporary social conditions of health.

Continuing on the lines of the missionary medical institution, the greatest threat to missionaries and the introduction of new Christian beliefs were THs and the people they referred to as witch doctors and sorcerers. According to Sobania (2004), the missions saw that their only way to counter these traditional
practitioners was to replace them at the local village level with Christian trained nurses and medical assistants. The good services and treatment provided by missions, including care for eye and ear infections during times of epidemics including influenza and smallpox, all worked to weaken and undermine the value of traditional beliefs and medical practices (ibid).

The policy approaches were thus not to reinforce the pre-existing public health systems, which Vaughan terms as customs and traditions related to healing practices. Tradition and customs were deemed enemies of health and progress in the missionary analysis, including the ‘arch enemy’, the traditional midwife. The midwifery practice which was/is associated with fertility and childcare was/is anchored in strongly held beliefs embedded within TMK. Vaughan quotes the colonial approach to women and TMK, whereby women as midwives and controllers of initiation ceremonies were an early focus of medical mission concern:

The African midwifery practices and associated ideas were believed to hold a large degree of social and moral control and regarded by both the missionaries and African communities as an area of great symbolic and medical significance. The missionary approach was that the social and moral control had to be broken if Christianity was to succeed [...]. The early accounts of the ‘darkness’ of the African birthing hut was positioned against the candles and white sheets of the maternity ward; while the elder woman who assisted in childbirth came to symbolize for the missionary institution the immensity of the ‘evil’ they were opposing in their work (Vaughan 2004:66).

The introduced alternative midwifery practices were embraced notably by those educated in mission schools with the combination of new technology and Christian ritual, seen as preferable to the moral control of kin exercised through traditional birth rituals. At a time when mother and child welfare was a growing concern in Britain, the medical missionary approaches made maternal and child health their ‘baby’, while it was neglected by the colonial state governmental health departments (Vaughan 2004). This shows that there were differences in preferred medical approaches between the colonial state and the missionaries.

Thomas et al. (2000) argue that for much of the 200 years since the ‘invention’ of international development, there has been an assumption that it is the state
(colonial, metropolitan or post-colonial) that is the agency best able to take on this trusteeship role – one of the features of the state as one of many organizations within society that sustains relationships with other agents within society. “It coexists and interacts with families, economic enterprises, religious organizations” (Azarya, 1988:10) and presides over “different spheres of the community” (ibid: 10). The relationship with (and approach to) the medical institution between colonial state governments and missionary societies during the inter-war period was a fragile one (ibid). The colonial government, though it recognized the value of the medical work done by the missionaries, was frequently critical of their work and especially of the training of medical assistants, nurses and midwives, subsidized by government funds. The evangelistic role of medical missionaries was seen as conflicting with their medical role. In the next section I will discuss the evolving relationship between TMK and the colonial state, while later in the thesis I discuss perceptions of THs regarding the governing structures and actors influencing TMK.

5.5 Traditional medicinal knowledge and the colonial state

During the entire colonial period in Kenya and Tanzania, colonial authorities were very concerned about traditional medicinal institutions, as they were perceived as a threat to the colonial project (Iliffe 2002). This can be seen in readings on other parts of the empire where similar policies were applied. In India the colonial administration was restrictive in its attitude towards indigenous medicine in government services (Bala in Nazrul 2010). The Western medical allopathic intervention is discussed as part of the “colonizing process” while “illustrating the more general nature of colonial power and knowledge”, with allopathic monopolization as part of colonial rule (Arnold in Nazrul 2010). The new tropical medicine legitimized and fixed the boundaries between metropole and periphery, and between colonizer and colonized (Worboys 2000). Nevertheless, according to Vaughan, there were examples of a kind of early attempt at medical pluralism:

David Livingstone advocated medical pluralism and tolerance ‘to keep on good terms with local medical men’ at all times, and not to ‘poach patients’ from them. He advocated that ‘all slight cases should be referred to local doctors and
'severe cases before being undertaken should be enquired into of the doctor himself' and 'no disparaging remark' ever made on the previous treatment in the presence of the patients (Vaughan 2004: 58).

As an early medical missionary and explorer, Livingston’s perspectives seem to advocate for tolerance between the medical establishment in the colony of Tanganyika and TMK, specifically the THs themselves. This advocacy to the medical establishment suggests avoiding taking patients from THs as well as avoiding discrediting THs in the presence of patients who had visited them, with the alleged purpose of not disturbing the relationships with the THs.

Despite the general condemnation of ‘traditional medicine’ as witchcraft in colonial ethnography in Africa, one finds early acknowledgement that African healing techniques comprised significant psychosocial components (Crossman et al. 2002). Crossman et al. (2002) describe some early studies that acknowledge the role of African TMK in social control, including African healing techniques comprising psychosocial components in addressing health and well-being. Bujra argues, however, that research and approaches to alternative epistemologies such as TMK have not been widespread in this region, although emerging studies exist on non-biomedical health practices as well as the regulation of legislation on TMK, as discussed in the empirical part of this study (Bujra 2000:101).

The Witchcraft Act of 1925 in Kenya, enacted to outlaw practices by communities that were perceived by the colonial government to border on witchcraft (Sindiga 1995), had the general intended effect of stigmatizing traditional African practices and beliefs, with a corresponding negative impact on local communities. In Tanzania the colonial government enacted the Witchcraft Ordinance in 1929, which was prompted by complaints about witch doctors. Witchcraft was declared a crime but was distinguished from ‘uganga’38 (Last and Chavunduka 1988). Even when colonial governments appreciated the existence of TMK alongside the introduced Western medicine, there was little effort to promote this knowledge field. Consequent efforts and official policy on TMK after independence have

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38 Uganga – divination by TH's
varied; and there are important differences in formal and informal perceptions, practice and policy on TMK between Kenya and Tanzania.\(^{39}\)

The approaches in the early colonial medical departments were predominantly preventive rather than curative. Turshen (1984) depicts colonial medical policies as having been designed primarily to protect the health of Europeans and to ensure the reproduction of the African workforce. However, parallel scholarship on the colonial medical establishment and policies in other parts of the empire has observed, for instance, an encouragement of the investigation of the value of local Indian Ayurvedic and Unani medical traditions and medical texts (Jeffrey in Nazrul 2010). This resulted in the establishment of the Native Medical School which taught both Ayurveda and allopathic medicines, which were later abolished\(^ {40} \) (Nazrul 2010). Vaughan’s scholarship indicates that, with the few professionals within the missionary establishment, medical services generally remained starved of funds with no state money initially available for native health care (Vaughan 2004), while much of the medical care was performed by laypeople with very little medical training or none at all (Koponen 1994). My understanding of the initial medical establishment is further elaborated in Johnston’s research, which describes temporary hospitals being constructed, with rudimentary Western infrastructure in the contexts where they were working, assuming a “quasi-physician status” with curative care as the only type of treatment generally at their disposal (Johnston 2010). Estimates indicate that by 1913 there were four missionary health centres with hospitals and qualified doctors in Tanzania all situated in the rural areas, (ibid) thus entailing an attempt to correct the colonial government’s urban bias.

Turshen’s (1984) research on the ecology of health in Tanzania reflects on the failures, neglect and inadequacies of public health policies by the colonial medical establishment. This is part of contemporary writings on the ills of colonial and post-colonial health institutions as discussed by Vaughan (2004). Critical reviews indicate that the realm of social and economic relations in health provision is neglected in the prevailing sophisticated technological epidemiological approach.

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\(^{39}\) These differences in laws and regulations, institutions and practices will be discussed in this study.

\(^{40}\) The Native Medical School was abolished by the colonial authorities in 1835, marking the end of the first attempt at a synthesis of Ayurveda and Western systems in India. See Nazrul (2010) for further reading.
to disease and health. The “natural history of disease” in Africa, scholarship argues is profoundly “unnatural” disease patterns of the 20th century which cannot be abstracted from the changes wrought by capitalism and colonialism in the modes of production and social reproduction (Turshen 1984). In other words, the scholarship explains that the introduced public health policies, which were to ‘replace’ the pre-existing traditional ‘public health policies’, were severely inadequate in addressing the socio-cultural, socio-economic knowledge and issues of social health and well-being in the societies in this region. I discuss aspects of this ‘inadequacy’ later in this thesis.

5.6 Contours of change

The subsequent changes in land policies and land rights in Tanzania and Kenya, and thus in Mwanza/Nyanza, following the colonial and post-colonial era may be interesting with regard to the control and management of traditional medicinal products related to the commercialization of TMK, which is discussed more broadly in the empirical section of this thesis.

The post-independence era in Tanzania (from 1961 onward) and Kenya (from 1963 onward) witnessed the continuation of the divide and rule strategy (initiated during the German and British presence, respectively); namely, the abolition of chiefdoms whose central role in managing ‘public health’ and TMK resources was altered. This abolition was to allow the co-existence between the different societal groups in both countries on the perception that they belonged to selected ‘tribes’ or ‘ethnic groups’. In Tanzania, chiefdoms were abolished in 1963 and new administrative structures were erected and reorganized in their place (Bukurura 1994). In Kenya, by the latter part of the 1930s the colonial government had installed marketing controls, stricter education supervision, and land policy changes. Traditional chiefs became irrelevant, and younger men became part of the administration through training in the missionary and civil education establishment.

The two colonial regimes in the two countries, as well as subsequent post-colonial governments in Tanzania and Kenya, seem to be partly associated with the
reorganization of the traditional political organizations and administrative apparatuses of the societies in this study, as part of their general administrative strategy through associated land policies. For instance, among the Sukuma, chiefdom systems which ‘governed’ TMK governing structures, e.g. rainmakers and other THs, experienced alterations in different ways. An alteration of the succession to chiefship from matrilineal to patrilineal descent took place in some areas (Bukurura 1994). The traditional administrative system was allowed to operate among the local people, with some modifications (Bukurura 1994). These organizations had, and still have, roles to play in governing TMK, for instance the Dagashida institution within the Sukuma societies which has been in existence for hundreds of years (Brandström 1990). It works with decision-making processes linked with TMK in the societies, and its ability to resolve conflicts has been well documented by Brandström (1990) and Cory (1954). While Cooper’s historical views (2001) explore a past in which economic and social relations were contained within nation states or empires and where interaction took place among such internally coherent units, the modifications carried out by the colonial apparatus may have created changes in traditional organizational structures that governed and managed TMK. However, the widely debated changing role and trends of the nation state in the past few decades is witnessing trends contributing to weakened states, which until now have had a monopoly on governance, administration and legal dimensions. This, it is argued, is occurring in parallel with increased agency and actors gaining more space and place in the aforementioned spheres of activities.

Other actors and agencies, such as (NGOs), are argued to have their early roots in charitable relief or missionary welfare organizations, later evolving into small-scale self-reliance approaches and even later into contemporary “sustainable systems development” (Korten 1990). While today it may facilitate governance and the development of private and public organizations, NGO activity is highly localized and often transitory (Edwards & Hulme:1992 in Thomas et al 2000). With a broadened role that may include advocacy, the provision of relief and welfare services in both countries, as will be seen later in this study. NGO

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41 Thomas & Allen (2000:197) indicate that “international donor agencies, non-governmental organizations at local, national and international levels, are gaining more influence in the governance and developmental space”, and argue that “just as when the nation-state became almost the universal mode of governance, the ‘cracks within its edifice began to appear’.”
mandates encompass spatial (local national and international), thematic profiles, while embracing public interest, research or campaigns, indigenous welfare and rural development while some aim at specific constituents (e.g. women, youth). Within the study area some of the NGOs working with TMK are highly localized while having a national profile in the two countries, the Eastern Lake Victoria Region and internationally. The NGOs in the study that comprise THs are exclusively localized in their spatial influence, which is mainly directed at welfare and rural development.

Despite the abolishment of chiefdoms in Tanzania in the early 1960s and later in Kenya, other forms of traditional leadership prevailed and are still relevant, for instance the *wazee wa mira*, ritual custodians and practitioners found in other parts of the country (Kweka 2004, Kajembe et al. 2001). Their role is defined in organizing rituals or punishing those who go against traditional village norms (such as cutting down trees that have TMK value, encroaching on areas set aside for ritual ceremonies, which is taboo etc.) through warnings or fines.

Chapter 8 of this thesis discusses TMK within the traditional and local communities as a resource that is mobilized, allocated, regulated and maintained while being passed over to subsequent generations. I will now turn to a discussion of the contemporary governance of TMK.

5.7 Traditional medicinal knowledge, the African state and governance structures

Scholars including Mathai (2004) and Bukurura (1994) discuss the contemporary role of the state in establishing legislation to govern natural resources including TMK, while the nation state and its role are described as a recent creation by Potter et al. (2004) and Thomas et al. (2000), which continues to decline in relevance (Strange 1996). The view is that the diminishing authority of the centralized state (localization), with its role increasingly shaped by the dynamism of global/regional mechanisms and flows, opens the floodgates to local popular demand for increased participation in public decision-making. Giddens (1990) describes the role of strong forces of a global nature through geo-political
globalization, with new forms of policy and scales of international intervention which translate into evolving state organizations that are more pronounced in some countries than others (Allen 2000).

The UN Economic and Social Committee (ECOSOC) defines the existence of governing structures, including the existence of a national policy framework on TMK as a measure or indication of national governments’ commitment to the Alma-Ata Declaration of 1978 as well as the WHO strategy of 2002 (ECOSOC 6385, 2009). This is the rod that signifies the commitment by member states in defining the institutionalization of TMK within national governance structures. In 1990 five member states had a traditional medicine policy, while by 2007 this number had increased to 48, which can be an indication of the increasingly significant role played by governments. Whereas in 1970 only 12 countries had a national research institute for traditional medicine, by 2007 this number had risen to 62 (ECOSOC 6385, 2009).

<table>
<thead>
<tr>
<th>Member States in the African Region</th>
<th>Regional Survey (37 countries)</th>
<th>Global Survey (141 countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Policy on TM/CAM</td>
<td>12</td>
<td>32 %</td>
</tr>
<tr>
<td>Law or regulation on TM/CAM</td>
<td>10</td>
<td>27 %</td>
</tr>
<tr>
<td>National programme on TM/CAM</td>
<td>15</td>
<td>41 %</td>
</tr>
<tr>
<td>National office for TM/CAM</td>
<td>25</td>
<td>68 %</td>
</tr>
<tr>
<td>Expert committee on TM/CAM</td>
<td>16</td>
<td>43 %</td>
</tr>
<tr>
<td>National research institute on TM, CAM or herbal medicines</td>
<td>18</td>
<td>48 %</td>
</tr>
<tr>
<td>Law or regulation on herbal medicines</td>
<td>12</td>
<td>32 %</td>
</tr>
<tr>
<td>Registration of herbal medicines</td>
<td>8</td>
<td>21 %</td>
</tr>
</tbody>
</table>

*Figure 5.1 WHO African Region: Positive responses on Institutional Framework for Traditional Medicine; Complementary and Alternative Medicine. Source: adapted from WHO (2005).*
The data in the table clarify the results of a survey by WHO on progress regarding the institutionalization of TMK and Complementary and Alternative Medicine in the WHO African Region. It shows the development of national policies and regulations on traditional and complementary/alternative medicines portraying significant progress. In particular, the high number of countries with national programmes, offices and research institutes on TM/CAM demonstrates an expanding commitment among African Region countries to promote and develop the scientific basis of African traditional medicines. However, the development of national policies and regulation, particularly for herbal medicines, is much more limited in this region, especially in comparison with the Global Survey response figures shown in the table.

The WHO Regional Committee for Africa has urged member states to prepare specific legislation to govern the practice of TMK as part of national health legislation and ensure adequate budget allocation that would provide for the effective development of traditional medicine (WHO 2002). Throughout Africa many health-oriented ministries are now encouraging the use of local medicinal plants, and have established departments of traditional pharmacopeia within the ministries to implement this policy (WHO 2003). August 2010 saw some nine African nations sign a protocol on the Protection of Traditional Knowledge and Expressions of Folklore. Being the latest in a series of international agreements and protocols on intellectual property rights, it was adopted in Swakopmund in Namibia by 17 member states of the African Regional Intellectual Property Organization (ARIPO) as a new legal instrument that “seeks to protect African traditional knowledge and folklore” (WIPO, 2010:1). The World Intellectual Property Organization (WIPO) terms this “an historic step for ARIPO’s seventeen member states, and a significant milestone in the evolution of intellectual property” (WIPO, 2010:1). However, an earlier UN report had warned against the application of Western legal and economic principles to collectively owned

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42 See CAM, defined in WHO 2002.
43 Of the 17 countries that are members of AIPRO (the African Regional Intellectual Property Rights Organization).
44 The draft protocol contains, among others, sections on 1) assignment and licensing; 2) equitable benefit sharing; and 3) the recognition of knowledge holders. It specifies that “any person using traditional knowledge beyond its traditional context shall acknowledge its holders, indicate its source and, where possible, its origin, and use such knowledge in a manner that respects the cultural values of its holders.”
knowledge in traditional communities. The challenge would be to translate the protocol’s principles into actual national legislation applicable to communities in their recognition as knowledge holders, and in the strive for them to obtain equitable benefit sharing. Mshana’s discusses (2002) protocols and the role of patents in the domain of the common:

[...]Past enclosure acts drove rural societies from their ancestral lands and rights. IPRs (new enclosure acts) will privatize the intellectual common and monopolize new technologies based on the common. The landlords of the past were/are transformed into the mindlords, while the eve of the 20th century witnesses the scramble for transformation from mindlords into lifelords and giga-giant cooperations.[..] (ibid 2002:206).

Finally, regarding the health sector, as part of a continent-wide trend of privatization of state corporations and government services, the majority of African countries are embracing the privatization of large hospitals where goals of financial independence have precluded the dispensation of free care and medicine (WHO 2005). An analysis of a number of national policies related to public health and medicinal plants presents issues which lean towards a failure to meet basic health conditions due to: the isolation of rural communities; inadequate decentralization of health services; and a persistence of TMK (Cunningham 1993). The result has been an underutilization of available services at health centres and high service costs in hospitals in relation to rural population incomes (Cunningham 1993).

45 I link this caution to the widely known indigenous opposition to the patenting of life forms, including plants, a reflection of an indigenous worldview in which every life form is sacred and is considered humankind’s partner in life’s unbroken web (Oguamanam, 2006).
6. Health and traditional medicinal knowledge in Tanzania and Kenya

6.1 Tanzania

In this section I present a context of the evolving space and place of TMK during the post-colonial era when new governmental policies were at play in Kenya and Tanzania. The chapter builds upon findings from a literature and documentation review, and key informant interviews based on THs’ practices and perceptions. The main source of material in this section on Tanzania was the literature review, while in Kenya the main source was notes made during interviews with respondents.

A brief description of the study area and its population is followed by a discussion on historical processes relevant to my research questions, such as the governance structures and organizational approaches to health, education and TMK. The period of interest is the colonial, post-colonial and contemporary time. In this chapter I discuss some roles of the various actors and the space and place they occupy at different levels of global, national and local governance structures relating to organizational policy, administration and legislation that govern TMK.

Drawing on empirical evidence and literature reviews on commercialization and commodification aspects of TMK, this chapter reviews the interplay between the contested international arena of access and benefit sharing and intellectual property regimes. The chapter therefore provides a colonial brief as a background to the contemporary organizational structures governing TMK.

As discussed earlier, the use of TMK is widespread throughout rural and urban Africa, including the study area. My study reveals some of the complexities of medical pluralism, which widely abound today in the study area. Traditional and modern health systems exist side by side, and people consult both systems for different reasons and stages of ailments. The emerging social livelihoods combined with an increasing presence of Western medicine are creating an emerging medical landscape.
In Tanzania, the Arusha Declaration for Tanzanian Socialism\(^{46}\) (1969) paved the way to extend primary health care to the rural population. Beck’s extensive writings on traditional medicine in Kenya and Tanzania indicate that the benevolent neglect that for several decades had characterized the relations between Western scientific health systems and TMK health systems began to yield to an attitude of benevolent curiosity. Western doctors and ‘native’ African doctors began to study the differences in concepts and patient treatment of the two systems to establish areas of cooperation (Mark in Beck 1981). It is also appreciated that, apart from the official attitude toward the THs during the final years of colonial government, literature abounds which provides a more balanced evaluation of how the mganga (TH) was perceived (Beck 1981). Thus, after 1960, I see the role of TMK already evolving; the question was whether it would be able to cope with the changes in political and social organization in Kenya and Tanzania:

Having been described as being early in the establishment of a policy climate to investigate the problems of co-existence of the two health systems, Tanzania is argued to provide an example of a more realistic appraisal of the role of TM in Africa (Beck 1981).

Prior to and following the Arusha declaration of 1969, the Tanzanian state intended to readdress the inherited colonial imbalance through an extended provision of health care to the rural areas (Swantz et al. 1996). The goal of this version of African socialism was more of an ideal than a structural base, serving as the only formative and uniting factor in national unity; thus, against this background, TMK with its belief in a non-material culture based on a particular cosmological paradigm was an untested force in the search for ideological unity (Beck 1981).

For instance, when the TANU Government took an interest in research in TMK in 1974, it concentrated first on the use of herbalists to supplement its supply of medicinal drugs with the medicinal plants available in Tanzania. It is this aspect

\(^{46}\) For detailed discussions on the socio-economic and socio-cultural impacts of the Arusha Declaration, see e.g. Swantz, Tripp et al. (1996).
of TMK that lends itself most readily to cooperation with scientists, i.e. chemists, microbiologists, immunologists and botanists (Beck 1981).

The post-independence objective of the Government of Tanzania to address the inherited colonial imbalance (Swantz et al. 1996) involved bringing more and better health facilities and expanded training programmes to the rural population. Though adjustments were made to the approaches, including reduced manpower training and personnel due to costs and production-related items in the development plan which affected health funds, Beck indicates 767 medical doctors in Tanzania in 1977, of whom 440 were Tanzanians (providing a 1:23,000 doctor-to-person ratio and one dispensary to five villages (Beck 1981). The medical auxiliary rose to 1,393 rural medical aides, though the goal was 2,800.

In 1974 the Tanganyika African National Union (TANU), at the time the ruling national government, instituted a policy for conducting research on TM in Tanzania, including a proposition to study the role its practitioners played in Tanzanian society including its traditional customs, in order to improve the health care delivery at the time (Beck 1981). Already ten years after the Arusha Declaration, the achievements of the health sector were examined by officials, who generally found that progress had been made in the right direction (Beck 1981).

The villagization process, or *ujamaa* 47, opened the floodgates to the mass migration of populations to villages country-wide, which also led to the establishment of some 3,000 rural health facilities and 17 regional government hospitals (Swantz et al. 1996). As a byproduct of villagization, the societies received a better water supply and better health and education facilities (Beck 1981). The major post-independence objective of bringing more and better health facilities to the rural population was continued. Although community health workers have been somewhat successful in alleviating health problems, the lack of medical supplies, facilities and physicians continues to make confronting illness a primary socio-cultural and economic survival issue. I argue that the

47 *Ujamaa* was the term used for the villagization of communities across the country – a state policy carried out following the Arusha Declaration of 1969. This resulted in Tanzania experiencing the largest forced migration of populations in modern times in Africa (See Swantz et al 1996).
aforementioned policy, as well as subsequent ones, tried to redress the imbalance in accessibility to modern health facilities in communities given the forced mass migration that was the key strategy of ‘Operation Vijiji’. The trend toward villagization, though it did not reach the expected goal of the *ujamaa* type of socialist settlements, introduced a new element into the style of rural population traditions. What would the role of THs and TMK be in the community within the villagization process?

In Tanzania the first national policy on TM was issued in 2000, while laws and regulations as well as a national programme on TM/CAM were being developed. The national office, established in 1989 as the Traditional Medicine Section of the Department of Curative Services, administered by the Ministry of Health, still exists. In an effort to promote and standardize TM, the national research institute on traditional medicine, the Institute of Traditional Medicine of the Muhimbili University College of Health Sciences at the University of Dar es Salaam, was founded in 1974 (WHO 2005, Mhame 2004). Traditional health services were officially recognized in the National Health Policy of Tanzania in 1990.

Today, the Government of Tanzania has in place a national policy on traditional medicine, in which is embedded the legal framework for institutional and community resource utilization and the management of TMK (WHO 2005). The governance of traditional health services falls within the Traditional Health Services Unit, which is mandated to mobilize THs to form their own associations as well as participate in the formation of the traditional medicine policy. In 2002, Act No.23 was enacted by the Parliament of the United Republic of Tanzania to make provisions for the promotion, control and regulation of traditional and alternative medicine practice (Mhame 2004).

The recent government policies on negative aspects of TMK, such as the phenomenon of albino killings, link with contemporary legislation on TMK and THs. Albinos in Tanzania are a vulnerable group, exposed to irrational killing with impunity, aimed at commercialization and marketing practices based on the

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48 Operation *vijiji* means the settlement or re-settlement approaches of people in villages between the years 1970 and 1977 for the purpose of implementing the villagization policy
belief that potions made from their body parts can bring luck, wealth and success. In recent years this phenomenon has attracted international condemnation, citing the killings as serious violations of human rights. Since 2007 over 50 albinos have perished in Tanzania, which suggests that this phenomenon is assuming regional dimensions (Alum et al. 2009), beyond Tanzania in East Africa and the Great Lakes Region (Yusuf 2008). Mwanza Region with its estimated 3,000 registered THs, the largest estimate in any region of Tanzania (Mushi 2009), has witnessed the largest number of murdered albinos (Whittaker 2011).

In response to this negative phenomenon, in 2009 the Tanzanian Government suspended and revoked the licences of THs, which effectively placed an official ban on practising TMK and consulting with clients. This was supplemented by numerous arrests, though some argue that laws “may mean little when they are neither supported nor enforced” (Dave-Odigie 2010). Some critics view this measure as having not acknowledged those THs involved in efforts to help identify culprits. While it is argued that “Witchcraft remains an unpleasant reality in everyday life” (Alum et al. 2009: 7), negative practices by witches, wizards and sorcerers are decried by THs, who lament the former groups as sabotaging the TH’s reputation (Interview by male TH 56 yrs in Mwanza 2009). This is within a new politie whereby THs are required to re-register, which is a lengthy and expensive process that includes a requirement that the TH have a certain number of rooms and separate sanitary facilities, pay a licensing fee etc. This may prevent THs from registering. The official approach, including the appointment of the first albino activist to Parliament in 2008 to advocate for the rights of albinos and secret ballot initiative in 2009, throughout all regions of Tanzania was to aid the identification of those involved in the trade in albino body parts (Dave-Odigie 2010). It is argued that the government’s interest in outlawing certain practices associated with sorcery through this initiative is legitimate, though it conflicts legally with the Tanzanian Witchcraft Ordinance of 1928 established during the colonial era, mentioned earlier, which remains a law today (Alum et al. 2009: 20).49

49 See further reading (Alum et al. 2009: 20, 26): The UN Human Rights Committee has criticized the Witchcraft Ordinance Act, and called for its repeal in 1998.
In a region where belief systems are widespread, where high value and reliance are placed on THs’ explanations for what and who is the cause of their poverty and misfortune, including at the political level (as well as in business, mining and fishing), where general social and political misfortunes can be premised on the belief in witchcraft50 (Makulilo 2013), it could be a challenging task to completely filter out the more destructive and dehumanizing elements of people’s cultural backgrounds and belief systems (Dave-Odigie 2010:73). Alum argues that, indeed, transforming a culture entails more challenges than simply enacting and executing laws (Alum et al. 2009:28). However, policy coordination and dialogue between countries (on defined regional issues) at the national and local levels are mechanisms which will increasingly occupy a wider space and take their place in enforcing credible rules (Potter et al. 2004).

However, similar to the case in Kenya, herbal medicines are currently not regulated as there are no restrictions on the sale of herbal medicines (WHO 2005). The sectors in which TMK is anchored are the health and cultural sectors in Tanzania and Kenya, respectively. In Mwanza, a Regional Strategy exists which guides the implementation of the national policy framework at the regional level51. Tanzania is one of the few countries worldwide to have initiated an online database on indigenous knowledge systems in Tanzania, including TMK52. Kenya’s Industrial Property Institute has as part of its mandate to initiate a similar database in Kenya, in an attempt to follow a model initiative by the Government of India.

The indigenous knowledge database is a product of the Tanzania Development Gateway, an initiative that uses information technology and the Internet to promote social and economic development within Tanzania. The database was established to enhance the sharing and dissemination of indigenous knowledge information, experiences and practices in Tanzania53.

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50 Witchcraft beliefs are not limited to a particular economic class, rural areas, non-professionals, or older generations, but are widely held across contemporary Africa (Abrahams 1994).

51 See Mwanza Regional Strategy for Traditional medicine

52 http://www.tanzaniagateway.org/ik/ accessed 27-3-2012

53 http://www.tanzaniagateway.org/ik/ accessed 27-3-2012
Figure 6.1 Reception at village hospital in Magu village, photo taken by author.

Despite some successes within the medical sector in Tanzania (there have been some strides in progress in reducing newborn and maternal mortality) towards the achievement of the Millennium Development Goal 5 (MDG5)\textsuperscript{54} and the Millennium Development Goal 4 (MDG4), both of which revolve around health and education, the modern health system remains fragile, even though— which implies a risk to the achievement of MDG4 and casts doubt on the achievement of MDG5 by 2015 (IHI: 2011). However, the MDG Report of 2011 states that “some of the poorest countries of the world - including the United Republic of Tanzania have made great strides in education” (MDG Report 2011), which indirectly influences MDG4 and MDG5. Here, the statistics provided by Mhame et al. (2010) on pregnant mothers in Tanzania are worthy of mention. The authors show that 97% of all pregnant mothers in Tanzania attend antenatal clinics but that only 47% attend modern health facilities during delivery, while 53% of all deliveries occur at home with the assistance of either traditional midwives or relatives. This provides theoretical evidence of the prevailing access to and provision of antenatal health care in Tanzania within maternal and child health care.

The access to and the quality and cost of formal primary health care still remain a challenge. In Tanzania, the provision of community-based health care has been significantly hindered by the lack of a trained health care workforce and other

\textsuperscript{54} The Millennium Development Goals Report 2011-UNDP
capabilities that forge critical connections between local providers and the populations they serve. Although the majority of Tanzanians live within five kilometres of a health facility, access remains a problem and outreach to communities and households is limited (IHI 2011). Beck confers that:

“The philosophy and social interpretation of health and disease has penetrated all areas of Tanzania’s economy, its social, political and scientific advance, and its attitude toward modern technology as well as traditionalism’ (Beck 1981:81).

The initiative described below illustrates and exemplifies the government’s aim at linking community primary-based health care services with TMK providers, providing the latter with innovative technology in order to sustain the link between the two.

The example is a state research institute, the Ifakara Health Institute in Tanzania, a health research institute founded on a strategy to bring research closer to communities. It is home to a project whose research aims to test a community health worker model for providing community-based health services and emergency referral to strengthen connections between communities and health facilities and thus to determine impact on child mortality, particularly newborn mortality. A model involving traditional birth attendants (also referred to as community health workers) will provide a connecting link between community-based health services and health facilities. The research focus, which targets the acceleration of MDG4 and MDG5, is to assist the Tanzanian Ministry of Health and Social Welfare in the testing and funding of a model for recruitment, training and deployment of community-based health agents as envisioned in the Primary Health Service Development Program (IHI 2011). Other institutions in Tanzania working extensively with TMK and conventional medical research include the Muhimbili National University Teaching Hospital in Dar es Salaam and the Bugando University Teaching hospital in Mwanza. I will now turn to another example of institutionalization of TMK based on my empirical material.
6.2 Kenya

This section is based mainly on discussions and interview material in combination with a literature review.

In Kenya the post-independence government recognized the close relationship between health and socio-economic planning; thus a national machinery for inter-agency collaboration was established (Beck 1981). The success of Kenya’s version of public health reflects a pragmatic programme with financial support from internal sources and donors, and vigorous enforcement through intersectoral coordination (Beck 1981).

In Kenya, we found a national policy framework for laws and regulations on TMK/CAM being developed. Respondents at the national research institute that conducts research on traditional medicine indicate that it was established in 1984, and is called the Kenya Medical Research Institute (WHO 2005). It conducts research on traditional medicines and therapies, while using WHO’s general guidelines for Methodologies on Research and Evaluation of Traditional Medicine (Oguamanam 2006). The Kenya Medical Research Institute has established special regulatory requirements for the safety assessment of traditional use of herbal medicines. However no control mechanism or registration of herbal medicine exists to ensure their implementation (WHO 2005). At the time of this study, herbal medicine is sold without restrictions.

According to researchers at Kenyan Resource Centre for Indigenous Knowledge (KENRIK), the Government of Kenya is in the process of finalizing a national traditional medicine policy framework, with the involvement of a number of sectors including the Ministry of Health, the Ministry of Gender, Sports, Culture and Social Services, the Ministry of Agriculture, the Ministry of Economic Planning and Development, and the National Environmental Management Authority. In 2003, the Department of Standards and Regulatory Services of Kenya’s Ministry of Health drew up a draft Bill outlining Kenya’s elaborate new policy on traditional health care and the regulation of its practitioners (2003). At the time of the respondent interviews a draft national policy on traditional
medicine, a document that had been submitted in August 2000, was waiting to be approved for debate by the Cabinet. It was launched in January 2007. Respondents indicate that a draft Policy Paper on TM is in place at the Attorney General’s chambers, as well as a Bill for its implementation. A sessional paper for that year was under publicity with eight regional submissions, including region-wide consultations.

According to the TMSEE, the Kenyan Government has fully recognized traditional health practices and systems, and wishes to incorporate it into national health delivery programmes, including insurance, natural medicines and traditional foods. Traditional health practitioners and other health workers are to be included at all levels of education. Like Tanzania, Kenya subscribes to the principles in the Alma-Ata Declaration of 1978, which stresses the need for any meaningful health care strategies in developing countries to introduce approaches for the provision of essential health services that correspond to basic needs, are universally acceptable, and allow for the full participation of communities themselves (TMSEE 2009).

According to discussions with representatives of KENRIK, the main bodies in Kenya working with issues of TMK include the Kenya Medical Research Institute (KEMRI), the Ministry of Gender, Sports, Culture and Social Services, the Ministry of Health, the Centre for Traditional Medicine, the Director of Medical Services, the Division of Pharmacy and the Drug Regulatory Authority. Although TMK today is mainly anchored in the cultural sector, numerous initiatives in other sectors such as education, health and development are active in shaping the use of TMK within the country. One key formal institution that works with TMK and indigenous knowledge in general is the Kenya National Resource Centre for Indigenous Knowledge (KENRIK). I will discuss this institution in detail in this section, based on interviews as well as literature and documents received from the organization, collected during fieldwork.

Interviewed researchers at KENRIK provided the information I discuss below. They indicate that KENRIK was initiated in 1992, is housed in National Museums

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55 Traditional medicine for social and economic empowerment (TMSEE) is an ongoing project in Kenya.
of Kenya in Nairobi and works for the promotion of indigenous knowledge in Kenya\textsuperscript{56}. It has a goal to document and promote indigenous knowledge in the country, and is a composite section with the Centre of Biodiversity, the department charged with Culture Heritage of Kenya, also housed in the National Museums of Kenya. A number of programmes and projects have been underway over the past decade, including programmes to promote the trade in traditional medicine supported by the Canadian Government. As community-based promotion of traditional medicine, it helped establish a network of medicinal plants and traditional medicine in Eastern Africa. KENRIK works with various thematic areas within TMK such as traditional food plants, traditional medicine and cultural sites, among others (the last with UNESCO involvement). I found that a great deal of collaborative work has taken place in the past ten years, most of it focused on traditional medicinal plants.

The interview material suggests that KENRIK’s strategic approach is for the future focus to be on issues of commercialization and policy direction. The strategy is the promotion of and work with THs and their organizations in areas including training, organization to promote trade, and promotion of the network of medicinal plants and traditional medicine in Eastern Africa. The two periods of 2000-2010 and 2011-2021 are the decades of African traditional medicine, as agreed on by the Inter-African Experts Committee on African Traditional Medicine and Medicinal Plants of the African Union. A continent-wide strategic framework has been established in collaboration with WHO to promote research and document TMK. Each year since 2003, on 31 August, an African Traditional Medicine Day is celebrated at the national level.

Respondents at KENRIK have worked with documentation and training over the past two decades. This work has resulted in documentation on traditional medicine, its uses and publications being stored in a database. Ethno-botanical data was in focus in the Canadian-sponsored project, with the IDRC\textsuperscript{57} supporting the Sustainable Use of Biodiversity Program for more than ten years. The recommendations from the project were that TMK should be prioritized on the

\textsuperscript{56} Interview material Kairuki P. (2007)
\textsuperscript{57} The International Development Agency for Research of Canada
political agenda, though more research is needed. Secondly, conservation training took place in communities concerning the sustainable use of traditional medicines.

The views below were provided by researchers at another key institution in Kenya working with research on TMK, the Centre for Traditional Medicine and Drug Research (CTMDR) at KEMRI in Nairobi, with field research stations around the country. KEMRI, a National Health Research Institute, conducts its work in close consultation with THs healers within the research programmes\(^58\). Respondents indicate that KEMRI also houses the Kenyan network on medicinal plants and traditional medicine. The researchers describe KEMRI’s research work on TMK as dedicated to, for instance, the areas of domestication and cultivation and the hygienic handling of patients. Botanists at KEMRI are also developing proposals on conservation. According to researchers there, the department’s main outputs include databases and operational networks; harmonization of research and collaborative projects; strengthening of traditional health practitioner associations; improving the acceptability of traditional medicine; and the formulation of appropriate policy and regulatory frameworks on traditional medicine. KEMRI sees some of the main issues pertaining to TMK as entailing conservation, cultivation, commercialization and certification options, efficacy, toxicology and standardization, documentation, access and benefit sharing, intellectual property rights, and integration with conventional practice. Some of the main activities of KEMRI’s Traditional Medicine Department are baseline survey, institutions, researchers and traditional health practitioner associations.

Being a Ministry of Health Parastatal organization that is trying to work closely within the Ministry’s mandate, the organization’s search for support for the sector’s policy in trying to allocate money for research continues. The researchers seem to indicate that within the research on TMK for chronic diseases, Tanzanian researchers are a step further than their Kenyan counterparts. This resembles a similar trend within the rural traditional medicinal practices whereby the ‘village

\(^58\) KEMRI’s CTMDR has a regional network within the Eastern African Region working with research on socio-cultural aspects of TMK and its involvement in the health sector. See www.kemri.org.
hospital model’ is more established in the Mwanza sub-study area than the Nyanza sub-study area, which I will discuss further later in the thesis.

Beck contributes that major goals in Kenya’s post-independence health policy did not differ from those of Tanzania, though their implementation showed a different character. Every citizen’s right to and acceptance of rural medicine as two prioritized basic principles were formulated and pegged into development planning (Beck 1981). In Kenya today, hospital-oriented medical care plays an important role in health care in the rural and urban spaces. Similar to Tanzania, a network of rural health centres began being established in the post-independence era and onward, coupled with substantial programmes for medical doctors and auxiliaries that were established and coordinated with other government departments (Beck 1981).

Researchers at KEMRI’s, CTMDR emphasize and describe some of the differences in approaches between how diseases are handled comparing conventional medicinal structures and TMK, as shown in the table below. This table was compiled after a session of interviews with researchers at KEMRI, during which they discussed some of these differences.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Viewpoint from TMK</th>
<th>Viewpoint from Conventional Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological problems</td>
<td>Background knowledge of persons being treated, source of psychological problems.</td>
<td>Better performed in modern surgical setting; skeptic on the instruments used to handle surgery.</td>
</tr>
<tr>
<td>Brain damage</td>
<td>Agusi brain surgery.</td>
<td>Scientific evidence not yet proven for some TMK medicines, funds needed to establish this.</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Some can only be curtailed, e.g. diabetes, hypertension</td>
<td>Conventional medicines are more active on bacterial diseases.</td>
</tr>
<tr>
<td>Bacterial infections</td>
<td>Medicinal plants that can be active.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6.2: Examples of approaches to diseases by TMK and Conventional Medicine- compiled from interview material. (2007, 2009).
The researchers in TMK also emphasized that research on some diseases at the institute involves both traditional medicinal researchers at KEMRI and Maseno University in close collaboration with THs. We later see some forms of collaboration in the Tanzanian and Kenyan study area between the district medical organizations and THs.

This recommendation resonates with extensive scholarship in Botswana on TMK and modern medicine denoting that modern doctors and medical researchers often compare the curative effectiveness in certain cases of diseases of their own system with that of traditional medicine. Such comparisons in most cases, it is argued, result in demonstrating the shortcomings of traditional health care; yet the whole concept of comparison is inadequate, as it is argued that TMK is far more than merely a system for the treatment of the manifest of disease (Staugaard in Last et al. eds: 1988).

One concrete collaborative model can be found in the training of traditional birth attendants59, established as an ongoing activity and strategy in a number of organizations working within the health and education sectors in the region of study. One main objective of training traditional birth attendants has been to make sure they practice under hygienic circumstances. We see similar models of collaboration in both study areas, where THs have received training in mitigating HIV/AIDS using safe sanitation and hygiene circumstances in their practices. Researchers at KEMRI and the university indicate that traditional birth attendants have been trained by government and donor organizations. The East African Network for TH, the National Museums, KENRIK, IDRC and KEMRI have developed training curriculum for the development of these practices.

Though it was emphasized by researchers at KEMRI that research and support are required to test and prove that the traditional medicine is effective, it was lamented that “science is slow”. The researchers saw some of the procedures as potential drawbacks, since products would need to be sent for purification. Some other challenges they pointed out were 1) the complexity of herbal medicines, 2)

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59 Traditional Birth Attendants are the equivalent of midwives trained in delivery techniques and gynaecology. They are recognized by WHO as THs, as well as for being multifaceted in their health delivery approach (WHO 2002).
the inadequate funds and machinery and 3) the required funds for exchange visits – for instance for Kenyan scientists to go to China and India. Some respondents emphasized one major difference in continuity in the use of TMK in the Kenyan setting (East Africa) in relation to the Chinese and Indian traditions. This I link to the effects of the colonial history in this region and the truncation of the TMK governing structures as discussed earlier.

The discussion resonates with what I discuss earlier in this chapter relating to the effects of the colonial project in Eastern Africa on the use and perceptions of TMK. This knowledge was devalued and its use discouraged through targeted legislation and colonial policy, whose legacies remain today. The traditional Chinese and Indian (Ayurvedic) TMK, perhaps due to their tradition of writing and recordkeeping, are today the most developed systems of TMK (Oguamanam 2006:142); which may also account for their progressive integration into, or intermingling with, Western medical science more than any other traditional medical systems. Scholarship suggests that the professionalization of TMK like Ayurveda in India followed the allopathic path as a result of the introduction of Western medicine during colonial rule (Leslie 1976), which could further explain why Western medical discourse and Ayurveda are both officially recognized schools in India. Also important to note is that during this period at the beginning of the 20th century, training courses in Ayurvedic medicine were officially transferred to various Sanskrit60 colleges, and were later separated (Nazrul 2010), which may have provided for some continuity in the development of learning systems of Ayurvedic medicinal knowledge.

Back to the traditional medicine healers’ associations, the respondent researchers indicated that the policy in Kenya should recommend the need for a board stationed at the Ministry of Gender, Sports, Culture and Social Services, which could bring together organizations of THs. In Meru District they are well organized, while the Department of Culture within the aforementioned ministry usually has its decentralized activities at the district level mainly in relation to the

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60 Sanskrit is the ancient language script in India. At the beginning of the 20th century, Ayurveda was separated from the numerous independent new Ayurvedic teaching institutions established in various parts of British India. Ayurvedic learning systems were integrated into educational curriculum, with some courses on Western allopathic medicine being taught side by side with Ayurvedic courses (see Nazrul 2010:780).
31 August- African Traditional Medicine Day, commemorated as a continent-wide initiative spearheaded by the African Union.

6.3 Intellectual property rights, globalization processes and regimes of traditional knowledge

In his extensive scholarship, Oguamanam underscores the contemporary intellectual property regime as an instrument of market economy, which is seriously unsuitable to traditional knowledge, the Intellectual Property Rights, globalization processes and regimes of the latter of which thrives in a socio-cultural context different from a market economy paradigm (Oguamanam 2006; Swantz et al. 1996). As I later discuss, indigenous and local communities and organizational structures usually lack the knowledge or systematic mechanisms to safeguard their collective property in the contemporary intellectual property rights organizational regimes. The argument is that the idea of a patent on plants was not enthusiastically embraced, with the definition that intellectual property rights are not only malleable, but also dynamic instruments for advancing national interests, for influencing social policy and engineering social change. Plants have become patentable subject matter in national and global patent regimes (Oguamanam 2006). The reference to the governance structures on IPR discussed in this study therefore attempts to view an arena where TMK as a collective property can converge with these contemporary regimes embedded in formal organizational structures.

The nature of the TMK debate highlights a double-edged sword: growing demand from strong economies brings with it concerns about misappropriation. The core issues are the growing call for: recognizing indigenous peoples’ rights; viewing TMK systems as “living” systems to be preserved; ensuring regulatory systems and safeguards against the commercial misappropriation of TMK (ECOSOC/6385, 2009).

Protocols and scholars advocate that informed consent of the holders of traditional knowledge must be obtained prior to its use (WIPO 2005). As such, there is a growing focus on how to prevent misappropriation. WIPO is focusing
on: draft provisions to protect traditional knowledge; “gap analysis”, which examines gaps in international law to be filled; legislative options for protection; as well as guidelines and measures to pre-empt the inappropriate patenting of traditional knowledge (ECOSOC/6385, 2009). Major policy issues are also being considered, highlighting first the need for a binding definition of ‘traditional knowledge’. Some scholars advocate for a binding treaty, while there is sufficient political interest to ensure at least a commitment to respect traditional knowledge (ibid).

Trade in traditional medicine at the international level involves legal protection and the mainstreaming of traditional medicines, which has been attempted by for instance the Government of India with the aid of its Traditional Knowledge Digital Library (TKDL). This exemplifies the problematic nature of IPR issues and some pragmatic approaches.

Taubman (2009) indicates that in the recent past, TMK was considered “background noise” in the globalized patent system. This has changed fundamentally, however, and today there is recognition that TMK must be considered on the same level as that produced by Western pharmacologists (see WHO 2003). An increasing number of nations, including China, Mexico, Nigeria and Thailand, have ‘integrated’ traditional and Western medical systems, particularly into their primary health systems (Balick & Cox, 1996). In Ecuador, for instance, the Ministry of Health is working on certification for THs and midwives working at the local level. Techniques used by THs are being examined, including gathering morbidity and mortality statistics for traditional medicine and comparing them to those for Western medicine (ECOSOC/6385 2009).
<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>70</td>
</tr>
<tr>
<td>Australia</td>
<td>48</td>
</tr>
<tr>
<td>France</td>
<td>49</td>
</tr>
<tr>
<td>USA</td>
<td>42</td>
</tr>
<tr>
<td>Belgium</td>
<td>31</td>
</tr>
</tbody>
</table>

Figure 6.3: Populations in developed countries who have used Complementary and alternative medicine at least once. Source: Report of a WHO survey. WHO (2005)

At the time of the study, the WHO Africa regional organization indicates that intellectual property legislation remains a relatively new area, which delays the development of frameworks for the protection of traditional knowledge and access to biodiversity in the majority of African States. Currently, IPR laws on traditional medicine are either non-existent or very weak, while there are still inadequate regimes for adequate protection of TMK and IPR in both Tanzania and Kenya (WHO 2010). In Tanzania, the government held sensitization workshops on IPRs in 2007 in line with legislation on the traditional medicinal policy (WHO 2010). The Ministry of Industry and Trade, through the Tanzanian Intellectual Property Advisory Services and Information Center, provides assistance to researchers and the general public in accessing patent information from different databases. The Patent Act as it stands today, however, does not protect traditional medicines and medicinal products derived from the flora and fauna of the country. This suggests that TMK may not be regulated (Mhame 2004). Efforts are now being made to establish rules and regulations governing IPR, with particular emphasis on equitable sharing of benefits derived from the natural wealth of the country.

On the other hand, inspired by the continent-wide African Regional Intellectual Property Organization (ARIPO) Protocol signed by countries in Africa, Kenya as a signatory has used it as a model to more broadly define legislation on traditional knowledge and genetic resources (WHO 2010). The government has seen to the establishment of the Traditional Knowledge (TK) and Genetic Resources (GR) unit at the Kenya Industrial Property Institute (KIPI), to specifically address issues of intellectual property rights relating to traditional knowledge associated with genetic resources for indigenous and local communities practising
traditional lifestyles, their traditional cultural expressions and access and benefit sharing issues. KIPI as a national institute within its TK and GR unit has a mandate to provide leadership in formulating national strategies to combat bio piracy, bad patents, and general issues related to TK, into which TMK falls (KIPI 2011).

Using a cross-sectoral approach, and in collaboration with organizations working with TK in Kenya, the KIPI is mandated to 1) develop official guidelines for intellectual property rights claims; 2) create awareness in local communities on the importance of traditional knowledge and genetic resources; and 3) identify individual and communities that are entitled to sharing of benefits and exclusive rights on accessed TK and genetic resources, including TMK (KIPI 2011).

### 6.4 Discussions and conclusions

Scholarship discussing TMK in a pre-colonial, colonial and post-colonial setting, as well as within a context of changing conditions in post-independence and contemporary Kenya and Tanzania, provides insight into contextual factors that may have influenced, and continue to shape, contemporary discourses on TMK.

The state (in this study) as an agency of governance continues to profile some continuity with policy approaches of the respective colonial administrations and core states in the 19th and 20th centuries as well as the post-colonial states after independence. The two countries have converging political institutions at the centre, Kenya with decentralized counties and Tanzania with regions where regional administrations function as decentralized government ‘states’. Global governance structures, international organizations and national governing structures continue to influence the life strategies and approaches of young migrants to and from urban areas in the study area. Contemporary scholarship by Mathai (2004), Potter et al. (2004), Thomas et al. (2000) and Strange (1996) attempts to define the role of the state in providing legislation to govern natural resources, including TMK. Global processes that increasingly contribute to an evolving health and education sector are characterized by an increasingly...

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62 Kenya had provinces as regional governance structures until 2013, when a newly reviewed constitutional process (2009-2013) established county governments.
privatized sector (WHO 2005, Cunningham 1993) while global, regional and state governing structures of TMK increasingly shape policies and regulations on it.

The discussions on social-spatial dynamics suggest that the colonial period saw the establishment of rural to urban and rural to rural migratory patterns and trends, as well as export-oriented economies that were/are intimately linked with land commoditization in the region of study. These migratory patterns, it is argued, continue to shape contemporary migration of youthful populations seeking alternative livelihood strategies and to diversify their informal strategies, as mentioned by Swantz et al. (1996), Laurenco-Lindell (2002) and Mwamfupe (1998). Neoliberal policies, which may change the structures of export commodities, have consequences on the rural and urban economies in the study area. According to Mwamfupe (1998) and Bryceson (2002), economies increasingly based on export and the commoditization of land have created a twin process of land shortage and associated deagrarianization (as prices for agricultural produce decline); urbanization patterns and the attraction of urban life have created economic opportunities for the populace, both rural- and urban-based individuals who diversify their livelihood-seeking strategies, including TH as a profession.

Both the Sukuma and Luo societies, which traditionally had a pastoralist and migration orientation, are seen to increasingly interact with the market economy in the region of study. The contemporary role of ecological factors in both countries, such as the loss of forest and tree cover, increased urbanization, changing land policies with an accelerated commoditization of land, all combine to further define the space and place for individuals to negotiate their livelihood strategies.

The close alliance between the establishment of medical institutions and Christian missionary work in East Africa, as documented by Vaughan (2004), Beck (1981) and Worboys (2000), albeit argued to be a fragile one (Azarya 1988), was characterized by the colonial state health institution, which relied heavily on the medical missionary institution due to its pioneering presence and longer experience among the communities. The missionaries provided the initial
institution of the health care and education sectors during the pre-colonial era in Tanzania and Kenya, while they continue to do so in the study area, as I will discuss later in the study.

Traditional ideologies surrounding TMK and ‘public health’ with social dimensions were not encouraged by the missionary and colonial enterprise, which Vaughan (2004) argues neglected women’s knowledge of social health and well-being. This echoes earlier research by Carter (1996) among the First Nations in Canada. Scholarship describes the abolishment of traditional chiefdom structures, which governed and were the overall custodians of TMK (including the social control of negative practices within TMK).

These policies which generally condemned TMK, established legislation in both countries that outlawed practices by communities perceived by authorities as bordering on sorcery and witchcraft 63, which had the effect of a general stigmatization of TMK (Sindiga 1995). This legislation, which existed side by side with some individual missionary efforts advocating for medical pluralism (Vaughan 2004), continues to provide the legal framework that criminalizes witchcraft and sorcery practices in contemporary Tanzania and Kenya, which I further discuss in the next chapter in the context of the albino phenomenon.

Despite this legacy, the early acknowledgement of the role of African healing techniques and their psychosocial components, discussed by Crossman et al. (2002) and Bujra (2000), shows an evolving relationship between the colonial authorities, who appreciated the existence of TMK alongside Western medicine, and THs, though little effort went into promoting this knowledge field. Critical reviews by Turshen (1984) indicate that the social and economic relations in health provision that characterized the prevailing TMK and its use in communities were positioned against introduced public health policies that were inadequate in addressing socio-cultural and socio-economic knowledge and issues of social health and well-being in the societies in the region. For instance, the abolition of traditional governing structures in the colonial and post-colonial era may have entailed alterations and modifications to how TMK was managed,

63 Worboys (2000), Nazrul (2010) and Iliffe (2002) discuss this as a general trend within the empire.
governed and legislated in the societies, according to Bukurura (1994) and Koponen (1994).

My discussion, which builds upon a literature review of Tanzanian studies and interviews respondents in Kenya, shows that TMK today exists side by side with modern health systems in what are seen as complex patterns of medical pluralism - some forms of which I will further discuss in the study. Scholarship by Beck (1981), Swantz et al. (1996) and others defines health and TMK policies in Tanzania in post-independent Tanzania as predominantly aimed at redressing the inherited colonial imbalance, including the appraisal of the role of TM and problems with the co-existence of the two health systems. The Arusha Declaration and the subsequent villagization process (which is argued to be the largest mass migration of populations in Africa in modern times) aimed to establish and improve rural and regional health and education facilities. According to the reviewed literature, Tanzania seems to have been earlier than Kenya in establishing national policy and legal framework for the institutional and community resource utilization and management of TMK, although the regulation of herbal medicines and restrictions on their sales still do not occur in both contexts.

The contemporary problem of negative aspects of TMK, including sorcery and witchcraft, which some scholars discuss, is premised on the widespread existence of belief systems that place a high value and reliance on THs’ explanations for why and who is the cause of poverty and misfortune at all social levels. Attempts to curtail these practices of witchcraft (which “remains an unpleasant reality in everyday life in this region” Alum et al. 2009:7), through pragmatic policy decrees by government authorities, are working to outlaw these practices in the same way the acts were enacted during the colonial era. Critics view these measures as unable to filter legitimate THs from those who practice witchcraft and sorcery, (Interview with male TH 40 yrs Mwanza in 2009) a factor that remains a challenge to organizations, communities and official policy. These practices are present within an arena of increased commercialization and marketing practices of TMK, alongside the impacts of neoliberal policies in

64 See Whittaker (2011), Alum et al. (2009), Mushi (2009) and Makulilo (2013).
Tanzania and Kenya, where health services have become privatized and expensive for the majority (Mshana 2002). I discuss the commodification and commercialization processes of TMK later in Chapter 9.

Beck (1981) argues that Kenya’s post-independence major goals on health policy were similar to those in Tanzania. Researchers in Kenya, however, re-emphasize the negation of TMK through targeted legislation, the legacies of which remain. While scholarship on TMK and development initiatives have been ongoing in Kenya, the respondent interviews later in the thesis imply that progress towards the development of a national policy framework developed by a group from various sectors for laws and regulations on TMK/CAM is in the pipeline.

This literature review and respondent interviews show that in both countries the development of legislation on issues of IPR and ABS regimes is ongoing in different stages. Both countries have government bodies mandated to work on developing policy and legal framework. The continent-wide organization of WHO and AIPRO, however, continues to advocate for a more proactive development of legislation and initiatives for the protection of IPR and indigenous knowledge, which would include the aspects of equitable access and benefit sharing for holders of TMK.
7. Formal and informal actors and organizations in the field of traditional medicinal knowledge

7.1 Introduction

In this study I endeavour to study TMK and related practices in changing societal contexts. In the present chapter I examine relations between formal and informal governance structures connected to TMK, based on my empirical material. I look at various actors and the space they occupy at different levels of organizational frameworks related to policy, administration and legislation governing TMK. The chapter dwells on empirical findings based on interviews with informants who work within various institutional structures as well as with THs and representatives of their organizations in Mwanza and Nyanza. I examine how these informants and respondents interact in the two study areas, which are embedded in nation states. The actors are linked to different formal and informal organizational structures that to different degrees shape the uses, management and learning of TMK. The chapter provides examples of state organizations\(^6\) involved directly and indirectly with TMK, and explores their relationships and linkages with individual THs and traditional healer organizations. The chapter concludes with a discussion on how these organizations affect stakeholder/-beneficiaries and particularly THs (both rural and urban dwellers) in their management and use of TMK and products.

7.2 Traditional healers and formal medical institutions in Tanzania - dynamics of collaboration

During the fieldwork, I found models of collaboration between traditional healer organisations and the formal institutions, which ranged from close and positive collaboration to that of scepticism, negative perceptions and non-collaboration. In Magu District of Mwanza Region in Tanzania I saw some form of collaboration between the two institutions, i.e. the Traditional healer organisation and the Regional Health Board. For example, one of the respondents was elected as a

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6 State organizations in the two countries include research institutes, district health facilities, university teaching hospitals, governmental organizations and regional governing bodies.
representative of the THs in the region on the Regional Health Board, which comprises medical personnel from the formal medical establishment:

That is why now they have chosen the representatives from the THs, me I am a representative on the board of the region; I am a representative of the treatment of traditional medicine on the Mwanza Regional Board. The reason is that the THs are organized within the district. We have also talked about electing the representative for the national board who comes from this district (Female TH, 36 yrs Magu, Tanzania).

The respondents pointed out an increased collaboration over the years between the two institutions, the TH association and the formal district hospital, as well as medical research centres. This has especially taken place after the change of institutional placement of the TH profession. In Tanzania, TMK and practices used to be placed under the Ministry of Information, Culture and Sports, but were later transferred to the Ministry of Health. The respondents point out how this institutional change has been an important factor behind increased collaboration between THs and district hospitals.

Have you seen changes over the years? When you started were you able to send people to the hospital?
Eh ...yes there are changes, now I can send them, like when I see that the patient needs ‘to be added’ blood, he has little blood or he needs water, or if examined and we find that he has a terrible cough. He needs to be thoroughly examined... Before I was unable to send people to hospital. This is good because when the blood level is low... sometimes he is delayed... Some say this one perhaps they have bewitched him... One day they came here from Muhimbili, the national hospital in Dar es Salaam, they came with the doctor who is the head of the district hospital. The doctor from here and health officer from the district, you remember, they passed through your place? (Male TH 62 yrs Magu, Tanzania).

The national representative, who would represent the traditional healing practices, saw that they were wasting the mira (traditional knowledge held by the THs) and they were grumbling... Long time ago the national THs used to be under the Ministry of Culture...under culture like here at the Bujola Museum, Bujola represents culture yes. That is why the THs have been removed from the Ministry of Culture to now be under the Ministry of Health (Male TH 55 yrs FGD Mwalina, Tanzania).

We were sent to the Ministry of Health. They took us there and that is why our collaboration with the doctors is good... and closer: we are able to be near, yes! Me I am grateful... even though they treat you negatively during the day ... and then at night they come and it’s ok (laughter)... But me for this I am grateful. Before it was never there... Actually really they have done well. You understand that this treatment, we can develop it in different ways, because even these
days they are coming from Muhimbili (university teaching hospital in Dar es Salaam) to come and do this research...(Male TH 40 yrs FGD Magu, Tanzania).

Within the same sub-study area, I met individual THs who had established a working relationship with the district hospital where they refer individuals; individuals whom they eventually realize they cannot help further and who require hospital support. This is illustrated in the following discussion. It also re-emphasizes the developing collaboration since the sector was moved from the Ministry of information, culture and sports to the Ministry of Health:

Sometimes in the night I wake up to give service, I sometimes see that this problem - I cannot manage it. In the hospital they have my file, perhaps they need blood or water transfusion. If I see that I cannot, I tell them they must go to the hospital; if I see that they do not have transport, I then help to take them to the hospital. I ask them to add a little ‘oil’ (petrol) as there is a tractor to help send them to hospital.

You have a file at the hospital? If I see the patient is suffering and to be treated, it is a must that I do so and he is sent to the hospital. At the hospital in Magu there is his file. So at the hospital there is our coordinator, he files our problem, if we tell him that we have sent him so and so. So he files him in our file (Male TH 62 yrs FGD, Mwanza, Tanzania).

The hospital’s people come here, the people who we send there are welcomed back here. The people we send to get water transfusion, after they are treated and given water, they are returned here to continue with the treatment here (Female TH 44 yrs FGD Magu, Tanzania).

We can give him the directions on use of the medicines and he can go home and ‘eat’ them at home. For instance, here he may not get milk from his home and get good nutrition and use the comfort. With help at his home he can become better. It’s good that they are in their own environment with medicine and food, there are diseases which extend to many years and months, but at their home they have time to look after him, there is time, they can get help with taking medicine and they can continue with their business and work (Male TH 60 yrs Magu, Tanzania).

The above citations also illustrate what I discuss in this study regarding TMK and the significance of the socio-cultural context in which it is embedded, which is largely absent in the formal medical institution. Scholarship discusses the nature of TMK and traditional healing, its pragmatic and spiritual basis, and the conditions for its coexistence with modern medicine in a developing country, as having become serious objectives of study (Beck 1981). The theoretical discussion in Chapter 2 and 3 of this study describes extensive scholarship that denotes and
defines how TMK has a specific socio-cultural context, which is perhaps the most defining aspect of this knowledge system as a benefit in healing ailments suffered by the individual (Oguamanan, 2006 and Mgbeoji 2006). The above discussion illustrates the individuals’ preference to relocate from the hospital institution (after undergoing treatment) to the traditional healer’s location. It is anchored on the premise that their wish is to relocate and stay/recuperate in an environment within a given socio-cultural context where their ailments can be addressed.

The following additionally demonstrates what I find to be the dynamics of cooperation and collaboration between the medical personnel, THs and individual patients:

The majority comes from the hospital. There are those who come straight here first, and then there are those who you ask ‘have you come from the hospital?’ They say ‘no I have not come from there’, perhaps when they get treated here and we see that they become still more sick then you take them to the hospital; sometimes they do not go, you go with them to the doctor, they take the examinations. They are given the drip for quinine, which they take when they are here (...) The thing which we cannot give to people is water and blood, and blood is not allowed to be added to someone at home; so with the ones like quinine, water, the doctor comes here. And the dose, he (Patient X) was being given the drip here, and we greeted each other and we prayed with them (Male TH 40 yrs FGD Mwalina, Tanzania).

Urban dwellers come here. There is a big hospital called Sumve. Their patients often come here... Even themselves, they send patients from Sumve. It is a big hospital, Roman Catholic. The Priest often comes here; he is the Priest of the church (Male TH 60 yrs FGD Mondo).

I conclude that a form of an ongoing collaborative model exists between the formal medical establishment and TH associations as well as with individual THs. The missionary health services, intimately linked and in close alliance with the Catholic mission establishment (the Priests), are seen to work in collaboration with informal TH services, and send patients to them. Traditional and modern health systems exist side by side, and people consult both systems for different reasons and stages of ailments. The urban and rural dynamics that link urban migrants to rural THs are demonstrated here in the need for people to return to the rural area for ‘rituals’ (Swantz 1996), where the need of a space for

66 Missionaries who pioneered the medical institution in the study region (Koponen 1994) provided the initial health care sector in the pre-colonial era in Tanzania and Kenya and, according to the empirical evidence, are still seen as important—‘a big hospital’ emphasizes the expanded role in health care services it plays in this area.
interpretation and action exists, so that cultural values can be upheld. The first quote above resonates with what I earlier discussed, that a large proportion of people who, for instance, are living with HIV consult both biomedical doctors and THs. This is supported by sectoral policy, in which TMK is embedded within the health sector. This is further defined below through concretized collaborative approaches between THs and formal sectoral support and within efforts to mitigate the HIV/AIDS Pandemic. This finding is in line with scholarship that illuminates approaches to providing a climate of co-existence between TMK and Western Biomedical practice in Tanzania. It serves to indicate that the policy trends from the 1970s in Tanzania have developed into collaborative mechanisms in Mwanza:

The TH as a diviner and herbalist had been on his own, aloof from government control under normal conditions. This had been one of the major objections. His secrecy made the medical profession and government uneasy, when ujamaa was introduced; traditional healing proceeded in a new direction. A new trend toward co-existence, with the approval of the state and medical profession, began in the early 1970’s (Beck 1981:74).

The earlier discussion on the apparent ‘erosion’ of state capacities highlights the issue of approaches by other actors and agencies in attempts to address social well-being in communities. Official development agencies such as WHO provide worldwide guidance in the field of health (WHO 2002), and cooperate with governments on national health programmes, with a role seen to encompass global, regional, national and local levels. Since the early 1990s, WHO has advocated for the inclusion of THs in national AIDS programmes. (WHO 2002). This mirrors the organization’s pluralistic view of health, as discussed earlier, which incorporates two epistemic responses to ill health, namely the Western scientific and the traditional or non-Western systems. In the case of South Africa, for instance, in 2004 legislation was passed by Parliament through the Traditional Health Practitioners Bill that affirms the importance of TMK as part of the overall health system (Pirani 2007). There are collaborative initiatives between the National AIDS Commission in Kenya and the Tanzanian AIDS

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67 The World Health Organization was established in 1948 (WHO 2002).
68 The WHO agency cooperates with governments in planning, managing and evaluating national health programmes, and promotes the development and transfer of appropriate health technology, information and standard in concert with global, regional, national and local actors and agencies.
Commission with THs in my study area, although a level of structured legislation similar to that in South Africa has not yet been established.

Researchers and development practitioners acknowledge that in order to reverse the spread of HIV/AIDS - which has a complex socio-cultural and socio-economic profile\(^\text{69}\) as well as intense migration components - THs are increasingly being involved in efforts and programmes in communities to mitigate and reverse the spread. As mentioned, the Eastern Lake Victoria Region has the highest HIV prevalence in the East African Community, which comprises Kenya, Uganda, Tanzania, Rwanda and Burundi (Drimie et al. 2009). Of Kenya’s eight administrative provinces, two had prevalence well above the national average of 7.4% in 2007, with Nyanza province at 15.3% followed by Nairobi at 9%. The study area in Mwanza has also been adversely affected by the HIV/AIDS epidemic, with an approximate infection rate of 20%, although some estimate that this rate may be higher (Alekal 2005). Youths between the ages of 15-24 are the group in which prevalence is increasing fastest (UNAIDS 2011), with the gender dimensions of females being more affected than their male counterparts.

The empirical material gives examples of how some formal institutions in Mwanza are working with individual THs on mitigation efforts, and the positive light in which the healers see this collaboration for the betterment of the communities:

Do you have condoms here?
Oh many, we have very many condoms here (laughter). They ask, so if they ask we give them, we show them how to use them. The hospital works with us on issues of UKIMWI (HIV/AIDS). I want to perhaps collaborate more with the government; to see how they can help, so they can help me more and we see. These days if I find strength to get help it would be good. We have also received training from them. Yes we buy razors and wear the gloves. We buy razor blades, sometimes 100 razors, and each person goes and disposes of his own razor in the toilet after use. We have ‘spirit’ which we provide and even if there is some blood spilt then it is used to wipe it clean.

For instance one day the hospital gave me a video for my village, because I have a TV here. They showed me how to install it and then the people in the village were able to see a demonstration on how to use condoms and to understand the problem of AIDS. I welcomed the people of the village to watch

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\(^{69}\) Further reading and research on the complex socio-cultural and socio-economic aspects of HIV/AIDS pandemic can be found in e.g. Kallings (2005) and Iliffe (2006).
the TV show on AIDS. There were many, even people from the neighbourhood. I saw that this is good for my village (Male TH 62 yrs Magu, Tanzania).

The above citation attests to the socio-cultural and socio-political influence of THs, which extends to a wider area, enabling a collaborative mechanism with the formal health sector. The traditional healer is a leader in his or her own right. This defines and illustrates the key role the THs play in their communities, which has been discussed by Staugaard and Beck:

The Traditional Healer is frequently consulted for religious and spiritual guidance legal and political advisor, marriage and family counselor (Staugaard 1985).

A wise man, a benefactor, a seer, but he antagonized those whom he accused of being responsible for illness, lack of rain, epidemics, and all kinds of misfortune (Beck 1981).

As discussed in previous chapters, the socio-cultural and socio-political influence of THs and traditional leaders is important, and both their historical and contemporary roles were frequently referred to by the respondents:

A long time ago there were THs but also there were watemi – (chiefs) yes...those chiefs even now his uncle is a chief\(^{70}\). When they were failed by the rain they tambika (went)... to him and it is as if these things are returning. So B’s uncle was a rainmaker?

Yes! A long time ago, yes a rainmaker. Now that Grandfather\(^{71}\) was also a ‘fishmaker’\(^{72}\). He would go and ask all the people that they should present to him a trumpet, the one like a cow’s horn/tusk, and would tell them ‘guys, all of you go tomorrow and catch fish’. He himself goes and washes his face like this (gestures with hands and face)...., then, the next day - fish!! Even if you come with a lorry, you come with a lorry, large (emphasizes with hands)... fill it, the fish do not get finished, even if you go in the evening at six o’clock, you will not find that the fish is all finished. And the fish it is really fish (emphasizes through tone of voice), people if asked would say they have been eating fish. You understand, and the rain is real and this information about the chief, it is in Bujola here (Male TH 55 yrs at the Sukuma Cultural Museum, Kisesa Tanzania).

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\(^{70}\) The use of the present tense is a metaphor that shows that the chief, though no longer living in Magu, is included among the ‘living dead’ ancestors.

\(^{71}\) Even though he was B’s uncle, due to his age and status he is referred to as Grandfather.

\(^{72}\) A fish maker- a metaphor signifying that he enabled the fishermen to catch many more fish than usual, not that he actually made fish.
The respondent above describes a rainmaker who was also a chief, who was able to use the TMK known to provide the community with surplus food. A large part of the text contains what I term tacit knowledge, where a great deal of information is contained in the discussion but is however not narrated. For example, why does he wash his face? Why present him with a cow’s horn/tusk? Among the Sukuma, the existence of chiefdom systems endowed the chieftaincy with defined responsibilities embedded in the governance of TMK. The example in the above citation is a rainmaker, whose role is synonymous with rainmaking and providing food for the community. These governing structures, as discussed earlier, experienced some alterations (Bukurura 1994), though Oestigaard (2010) and Brandström (1990) show the contemporary roles that are still played by some TMK governance structures in Mwanza.

Collaborative mechanisms on the increase in the region include training in practices to reduce the transmission of HIV/AIDS, i.e. including safe hygiene and sanitation practices. The traditional healer above and other respondents indicate that they have also received training in efforts and certain aspects of reducing the transmission of HIV/AIDS. This included safe hygiene and sanitation practices; the use of rubber gloves during consultation as a standard practice; the sterilization and disposal of razor blades between patients; and the distribution of condoms while teaching the patients about their safe use and the recognition of TB and HIV, while promptly referring them to health centres.

THs equipped with referral, counselling and communication skills, coupled with timely and accurate information on HIV, can contribute to HIV prevention, care and support. An example whereby such collaboration has worked to reverse the spread, prevalence and incidence of HIV/AIDS is in Uganda through the collaboration between traditional and modern health practitioners. Another joint traditional healer and formal health institutional collaboration can be found

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73 Oestigaard’s (2010) research in Mwanza argues that the chieftaincy and rainmaking role is an intrinsic part of culture and traditional religion, which is defined by the power to control disasters and aid in the fertility of the fields, the health and wealth of humans and animals, epidemics and plagues, and offer safety from attacks by wild beasts. His governance embraces a responsibility for the wealth and health of his people by controlling and providing the life-giving waters. Through rituals in which the forefathers and the deceased provide rain through the chieftain or the king as a medium, the rainmaker provides support to his communities (see more at http://www.nai.uu.se/research/areas/rainmaking-and-climate-ch/).

74 THETA is a Ugandan NGO formed in 1992 whose aim is fostering collaboration between modern health workers and TH. It was formed as collaboration between the AIDS Support Organization (TASO) of Uganda, a national NGO providing care and support to people living with HIV, and the international humanitarian NGO Doctors without Borders, with the support of Uganda’s National AIDS Control Programme and the Uganda AIDS Commission.
in Tanzania, with the Tanga AIDS Working Group (TAWG), formed in 1992 by a group of health care professionals with the primary aim of collaborating with THs and enabling early referrals of HIV-positive patients with treatable conditions.\textsuperscript{75}

Strategies that have been successful in the cooperation between African TMK and biomedical medicine also point the way forward for establishing and expanding collaboration with African traditional medicinal practitioners as part of a broader and more efficient approach to community-based HIV prevention and care\textsuperscript{76} (Homsy et al. 2009). Pirani (2007) argues that success initiatives for such collaborative ventures as the above-mentioned case are not only through the eyes of the formal health system but also the community expressing gratitude for improved skills and knowledge of the THs as well as the increased coordination between THs and health centres (Pirani 2007). Given the multisectoral nature of the pandemic, development practitioners concede that such collaborative initiatives are of great value as they allow them to give better care to people in the communities (Hlabisa in Pirani 2007).

In my empirical study I found support for the idea that THs are eager to collaborate with modern medical institutions. THs can be unique allies in reaching the communities in a socio-culturally appropriate and sustainable way. I therefore echo Homsy et al.’s (2009) recommendation that policymakers, public health officials, donors and other researchers recognize that the conventional health care system on its own has not been and will not be (in the foreseeable future) in a position to curb the spread of, for instance, HIV in the study area without engaging the help of all relevant stakeholders, including THs (Homsy et al. 2009).

A further example of a HIV/AIDS intervention related to TMK is intergenerational programmes (see Chapter 2), which draw on learning practices developed within traditional knowledge systems. In South Africa, learning processes on HIV/AIDS highlight the renewed role of the \textit{new parents} in mitigating AIDS, and attempt to bridge the gap in the changing extended family

\textsuperscript{75} TAWG has to date trained 429 THs, including 87 TBAs (Homsy et al. 2009).

\textsuperscript{76} A comprehensive Documentation of Collaborations between TH and Biomedical Health Practitioners for Prevention and Care of Sexually Transmitted Infections and HIV in Sub-Saharan Africa (2000–2007) can be accessed through Homsy et al. 2009.
structure and subsequent implications for the youth. This exemplifies a more formal TMK learning, especially for the youth, in transmitting important knowledge directly linked to reproductive and socio-cultural and socio-economic issues. These are at the heart of the pandemic’s problematic spread and therefore a relevant area for intergenerational programmes. As exemplified in Chapters 2 and 3, intergenerational or non-familial learning processes can in different geographical and social contexts provide learning in programmes targeting the youth. I will now turn to the perceptions of the THs in Kenya concerning the meeting points with formal institutions, as expressed in the individual interviews and focus group discussions.

7.3 Traditional healer organisations meeting formal institutions in Kenya – subordination and conflict

Traditional and Modern systems of medicine were developed by different philosophies in different cultural backgrounds. They look at health, diseases and causes of diseases in different ways. These differences bring different approaches to health and diseases. However, both systems deal with the same subject - human being. The old and modern arts of healing should exist together (WHO: 2002: 2)

With the above statement WHO indicates that medical pluralism is a reality, and through its mandate promotes and encourages the combined approaches of the two systems of health. However, this relationship has not always been harmonious. Researchers I interviewed in Kenya exemplified parallel historical governing processes that have played a role in how contemporary TMK is governed and perceived:

The Chinese and Indian TMK systems have had fewer breakdowns due to colonization. TMK has been less disrupted to a large extent in the community as compared to the East African setting. We were brainwashed, trained in the conventional way. We are trying to get it back from where we left it. TMK is definitely in the mainstream within the communities (Female Researcher 55 yrs at the NGO Moringa Organization, Homabay, Kenya).

Some respondents emphasized a major difference in continuity in the use of TMK in the Kenyan setting (East Africa) in relation to the Chinese and Indian traditions. This I link to the effects of the colonial history in this region and the truncation of the TMK-governing structures, as discussed in Chapter 5 and 6.
This knowledge was negated and its use discouraged through targeted legislation and colonial policies whose legacies remain today. The above researchers’ comparative views, as well as scholarship on Chinese medicine and Indian (Ayurvedic) TMK, show that perhaps due to their tradition of writing and recordkeeping, “these are today the most developed systems of TMK; which may also account for their progressive integration into, or intermingling with, Western medical science more than any other traditional medical systems” (Oguamanam 2006:142).

The THs who have organized themselves into associations mainly emphasized what they perceived as a lack of proactive commitment by the Kenyan government authorities to their cause. They saw this as the case in the Nyanza sub-study area, despite the well-known fact that they contribute significantly to development and well-being of populations in rural and urban communities in the region. In the study area in Kenya, the traditional healer organisations lamented the lack of firm commitment and support from the government to local organized associations like theirs. They were also critical of the research institution KEMRI. Perceptions included inadequate financial and infrastructure support and restrictive legislation, for instance with licensing requirements, as indicated in the citations below:

The government does not give the Ministry enough funds to enable cooperation. We sent a proposal to the Ministry of gender, sports, culture and social services (which is the sector that houses TMK). They want to take a lot more from us. They take the knowledge that we have and give them, they go and use it but no one comes back (Male TH 56 yrs FGD Homabay, Kenya).

Does the government help you?

Not yet, there is nothing they have helped me with even once. Yes I want a licence from the government.

In the way of treating, how have you helped the government?

I help them a lot. I help their people; people who had become useless because of alcohol and had left their jobs... I help the government through helping its people; have I not helped them? (Male TH 60 yrs Gem, Kenya)

Our leaders trouble us a lot, if you do not have a licence. If you want an original certificate you have to have five of your medicines tested. At KEMRI, 5,000 KSh (USD 65) is required for the test. Conmen are also there at KEMRI. If they discover that you can treat then you will never use that medicine. If you go to
KEMRI then they want to employ you and share the amount of money. They even ask us to go to a seminar for 30,000 KSh (USD 375)! How will we be able to pay when each patient pays 50 KSh (USD 65)? Our thing is not going forward! (Male TH 55 yrs FGD Homabay, Kenya).

This medicine, which is used to treat humans, dust should not be allowed to settle on it. We want to be able to have a relatively good place to sell our things. It rains on us. In this place of ours no one remembers us. When we have paid the licence fee of 40 KSh (USD 0.5) no one cares again about us. The municipality people should come and take a photograph and build for us a place to work (Female TH 35 yrs FGD Homabay, Kenya).

Respondents from the National Organization for Indigenous Knowledge (KENRIK) indicated that in Kenya, THs are required to register with the Ministry of Culture and obtain a recognition certificate. This requirement is also in place in Tanzania, where the government requires THs to be formally registered and obtain licences. This has evolved from the early policy, for instance in 1933, when the “chief secretary of government in Dar es Salam decided to leave the registration of the native doctor to a later period when more would be known about him and his ability to cooperate with the established medical system” (Beck 1981:70). Staugaard (1985) discusses one of the options of health care planners in developing countries regarding official attitudes towards simple legislation regulating TM. His argument is as follows:

Simply licensing THs does not imply any regulation of TM. Simple legislation might regulate certain negative effects of traditional practices but does not seem to imply any substantial improvement of the comprehensive health care system of the country (Staugaard 1985).

According to the informant interviews, another requirement is to submit samples of all the herbal medicines they use to a scientific institution for testing – either to the Kenya Medical Research Institute (KEMRI) or to the University of Nairobi. In addition, the traditional healer has to provide information on the names of the plants, the parts used, and the methods of preparation, administration and dosages. Among the THs I interviewed this was perceived as quite expensive, and without funding support from authorities or the private sector, almost impossible due to the low payments they receive from their beneficiaries.

77 The strategy established by the Government of Tanzania five years ago to curtail the negative effects of the albino phenomenon in the country.
As described by the male respondent below, there exist some conflicts of interest between THs and the formal medical research or health establishment:

There are conflicts between modern health and traditional medicine. Modern health officials think we are primitive. I was at the hospital to help people in the modern hospital and they accused me of being unmodern. They asked me for my certificate and accused me of being illiterate and said they could arrest me. The modern medicine has a superiority complex (Male TH, 62 yrs FGD Homabay, Kenya).

This view is in line with Beyer’s (2009) scholarship, which shows how societies may evolve into cultures that place less value on their indigenous knowledge, especially their ethno botanical and TMK. A form of legacy exists in Worboys’ term “legitimization of the new tropical medicine”, which fixed the boundaries between metropole and periphery and between colonizer and colonized (Worboys 2000:207). The hierarchical relationships discussed by Dahlström et al (2006), which dictate and are closely related to power of preferential right of interpretation including what counts as appropriate knowledge about health practice, may be included here. The THs’ health knowledge is categorized as ‘primitive’, thus placing it within a hierarchical relationship with the health knowledge at the formal hospital.

There were nevertheless examples of forms of collaboration between KEMRI and THs, discussed by one of the male respondents below. In this case, the traditional healer adapted his practice to the working procedures elaborated by KEMRI researchers:

I was able to work together with the KEMRI clinicians, developing and making preparations under KEMRI’s supervision. This was done while the health of the patients was monitored by the clinicians, the so-called observation studies. I work in my practice with respiratory diseases like asthma, TB... (Male TH 60 yrs Gem, Kenya).

While this form of cooperation was perceived as positive in many ways there were several THs in the Kenyan setting, including representatives of their associations, who described finding themselves in a subordinate position in relation to the research institution and the formal medical establishment. This illuminates what I discussed in the theoretical framework about how traditional knowledge may be
presented as backward, antiquated, static and inferior to Western science and thus ‘primitive’. For instance, in research on Aboriginal health matters in Australia, the National Aboriginal Health Strategy disclosed that the government departments and health system there “denies a locally-based indigenous perspective on health matters” (Fatnowna et al. 2002). It develops into a scenario where control at all levels of policy, registration, health economics and research is firmly held by the medical institutions and profession (ibid). Alternative scholarship, however, shows that traditional knowledge is an aspect of the cultural dynamics of its practitioners (Oguamanam 2006).

Thus, the meeting point with the formal medical establishment in the sub-study area in Nyanza was characterized in the respondents’ narratives by harassment, and a lack of both proper premises allocation and a voice to express the THs’ concern. This echoes the argument in the scholarship, which refers to the disdain of traditional therapeutic methods and their custodians by Western biomedicine, discussed earlier in Chapters 2, 3 and 5. In both study areas, but particularly in the Kenyan context, I identified an overall state control over policy issues and funding which, according to my informants and respondents, translated into control of professional recognition of the THs’ services, training, legitimation and development. My analysis of the two contexts shows, however, important differences between the contexts in Kenya and Tanzania. Oguamanam (2006) nevertheless argues that there exists a general pattern of subordination, based on an epistemic conflict:

(t)he crux of the schism is the desire by the latter, in alliance with the intellectual property system (patent), to set the so-called scientific standard for traditional therapeutic systems generally perceived as unscientific. The perception that TMK is unscientific derives in part from its multivalent methods, which place the TH/Shaman at the centre of a raging epistemic conflict (Oguamanam, 2006:137).

I found an important difference between the collaboration with the organizations and some THs in Mwanza as compared to Nyanza. There was clearly a working collaboration in place with the district hospital in Magu and Mwanza between registered individual healers and organizations, which was less structured and developed in the Nyanza sub-study area. Respondent researchers from the formal
Our neighbours, countries in the region such as Tanzania, have gone further. For instance, chronic diseases are documented. We need research to find a way to change people’s minds. In Kenya it is difficult. A lot of scepticism from conventional doctors and some institutions exists, while it is difficult within observational studies to find a clinician on board who is not sceptical (Female Researcher 52 yrs KEMRI, Kenya).

Nevertheless, researchers in the formal organizations in Kenya have the mandate to collaborate with TH organizations, as mentioned by the informant below:

The overall objective is to promote the conservation and sustainable safe and effective use of medicinal plants and herbal products as well as the integration of traditional medicine in public health services, through effective collaboration among all stakeholders (Female Researcher 32 yrs KENRIK, Kenya)

In some instances in Nyanza I saw some minor form of collaboration between the conventional health establishment, the formal hospitals and traditional birth attendants in the training of TBAs, though not structured, as indicated earlier as well as in the citation below. An established traditional birth attendant in the region worked with the district hospital in training younger birth attendants. Her son, whom she had trained from childhood, had worked at a larger private hospital in the largest town in the region as a midwife:

Have you taught someone? Yes the wife of my son and my son J, the big boy, they know. He knows how to deliver babies. Even the days he was at Agha Khan Hospital, he used to work as a midwife. Even his wife knows cholo. (To aid women in giving birth). J was working at AK Hospital. Even those who have come from the district hospital who have taken this line want to know how to do this work and they brought from the school a boy and girl to learn (Female TBA, 52 yrs Homabay, Kenya).

My wife knows about traditional medicine for traditional birth attendants and she is at present working for World Vision in Lambwe Valley (Male TH 69 yrs Suba, Kenya).

The traditional birth attendants form the group of THs that has had closer training and approaches with the formal organizational structures, according to informant researchers from KENRIK and KEMRI. The case above shows how TMK was transferred by a female TBA to both her son and, subsequently, her
daughter-in-law. As I will discuss in the next chapter, I found that gender was not central in how THs taught their knowledge to an apprentice – male healers taught female apprentices and vice versa. Of more importance were the personal traits and characteristics of being obedient, being receptive, having a good memory and being able to keep secrets (see also Mwiturubani 2009). These are traits that an apprentice is required to have in order to be able to learn TMK.

The perceptions of the THs in the Nyanza study area on institutional policy also revolved around the fact that changing the sector where TMK is anchored and/or establishing a separate department for THs would ease their professional work:

If we are given our own department for THs then we can treat properly. We are specialists in what you want to treat, and this thing could go forward (Male TH 56 yrs FGD Homabay, Kenya).

Here I found a difference between the two sectoral approaches in Mwanza and Nyanza. In Magu District in Tanzania the THs have an associative collaboration with the district health authorities with THs in the empirical study registered with the District Medical Offices in Magu. Whereas in Tanzania the professionals and working policy for TMK are embedded and housed within the Ministry of Health, in Kenya they are housed within the Ministry of Culture and Social Services. The THs in Nyanza advocated for a better defined policy that would allow for a review on the sector in terms of where they can be anchored and which could provide them with optimal support in their profession. At the same time, it has become clear that a number of sectoral initiatives and institutes work with TMK, including KEMRI, KENRIK, the National Museums of Kenya, the Ministry of Health and Centre for Traditional Medicine, the Director of Medical Services, the Division of Pharmacy and the Drug Regulatory Authority.

The ownership of policy initiatives in Kenya is nevertheless not as clear as in Tanzania. In relation to this, Oguamanam argues that “despite a cautious or cold reception of a draft bill (outlining Kenya’s elaborate new policy on Traditional health care and regulation of its practitioners), by the country’s medical profession, the bill appears to have commenced on a tortuous journey to becoming an act of Parliament” (Oguamanam 2006:105). My findings indicate a
clearer focus and a more positive policy climate in the study area of Mwanza than in Nyanza.

In both countries’ major cities, I observed numerous new advertisements on various street corners in both Nairobi and Dar es Salaam by urban THs advertising their trade (see example figure 7.1). In relation to earlier periods, there is a stronger presence and acceptance of TMK within the urban space, which was also frequently expressed by the respondents in my interviews (see Chapter 9). Even though I found differences in the organizational dynamics and problematics in Tanzania and Kenya, a common trait was the increased urban presence and the strengthened links to the formal medical institutions over time. Cunningham (1997) and Wondwossen (2005) similarly observed an abundant increased urban presence of TMK in their research related to urban space and the commoditization of TMK in South Africa and Ethiopia, respectively.

![Photo of TH advertisements in urban space](image)

*Figure 7.1 TH advertisements in the urban space, photo taken by author.*
Figure 7.2 Aloe Vera\textsuperscript{78}, planted and growing on the hospital grounds, at village hospital, photo taken by author.

Figure 7.3: Ritual site and entrance to the village hospital, photo taken by author.

### 7.4 Actors and power relations

They come at night and do not like daytime (Male TH, 40 yrs Magu, Tanzania).

Although the discussion in the previous section illustrates an increased stance of collaboration and dynamics within the communities between the THs and the formal medical and research institutions, the empirical evidence also reveals some cases in which negative perceptions still existed within formal institutions like the church and the political establishment. Some respondents indicated that

\textsuperscript{78} Example of a widespread traditional medicinal product used in the local study area as well as in refined form in the commercialized pharmaceutical industry.
though the negative perceptions persist, “during the night” they were visited by individuals who constantly request help and who work for these institutions:

Even Priests! Father K, there in Rome. He was here at the mission. Nowadays he is in Rome. He was ill (kugua) there in Rome (...). He was treated very much there (emphasis voice tone) by the Priests. He was told by them ‘now your work about reading is over, you return to Tanzania, or if you get healed inform us’. They came and brought him here, you know them they do not like daytime, he was brought at night in the late evening at around 7 or 8 pm, ah! (...) We gave him the medicine. For a week, he then told me ‘I have healed; I want to return to Rome’. But he was also being disturbed by spirits (mizimu) (...) He was wrapped with all the medicines, now he has been seven months in Rome. Nor has he any problems (Female TH 36 yrs Mwanza Tanzania).

The above respondent describes a Priest whose approach to health, illness and therapy involved access to the formal health establishment in Rome, while later complemented by the informal TH services in Tanzania. The individual, with a prolonged period of illness, was advised to return to Tanzania and when healed to return to his work in Rome. The respondent tells how the Priest accessed the respondent’s TH services - though “he was brought at night”. His behaviour exemplifies two epistemic responses to ill health and disease, which I discussed in Chapters 2 and 3. He uses both Western and traditional medicines, which in combination reflect a pluralistic view on health. As noted before, a pluralistic theory accommodates biomedical and psychosocial paradigms, associated with Western and non-Western/traditional approaches, respectively. The Priest accesses the informal services of the TH profession alongside the formal professional role embodied within the church establishment. Informal power relations may exist between the traditional healer and the Priest whereby the healer’s approach to illness and well-being is sought as a social, patient-centred/oriented epistemology tailored to the particular needs of the individual who sought therapy within the alternative epistemic response to his ill health. This is an example of the patient-traditional healer dynamics discussed by Bode (2006). Castells (1996) and McGrew (2000) also discuss interdependencies, increased contact and transformational dimensions of the social landscape of human life, for instance when individuals who originally resided in the local mission migrated and later returned to continue a formal profession. Informal and formal power relations exist between the healers, politicians and other professionals:
And the leaders, perhaps of the government? They can come? Mm! Yes like when it is near the elections. They come very many, different ministers, permanent secretaries, leaders, different ones...So they come...That one we went to visit is the District Commissioner. The likes of OCPD\textsuperscript{79}, we treat... they too, they are in fear of being seen but we show them how to heal (Male TH 62 yrs FGD Mwanza, Tanzania).

So Priests, sisters, nuns... Yes! Many nuns they come here to be treated but they say 'we are not really allowed to come here but we are just begging for treatment'. Like now a former classmate of mine he is a Priest. He asked me for help (laughter). For instance, once I went to a certain mission, I met a certain sister-nun. She had her project to raise chickens and for patients a dispensary, she wanted me to do for her some treatment and prayers. She told me ‘my patients do not heal, I treat them but they do not heal...why? And yet we have all the medicines, we have everything’ (Male TH 56 yrs FGD Magu, Tanzania).

There are some groups, churches and individuals, even the government, they say that THs are very bad. They do not say the good things about the THs only the bad things. And yet they visit the TH and come at night, even these days when people have education. They come to the TH at night but at the same time during the day they say bad things and condemn the THs. This can interfere with people’s psychology. Some Priests for instance who at times come at night but at the same time they say negative things about us, publicly! It is behind the scenes. In the night you are helping him, so as the Swahili saying goes, he is *kushirikiana*\textsuperscript{80}, during the night, and in the daytime he is burning you. Those ones, they do not want to beautify our work! (Female TH, 44 yrs Magu, Tanzania).

These respondents emphasize the paradox of formal institutional actors who condemn all aspects of TH in the formal arena, while in secret they visit the TH, even ‘these days when people have education’. This relates to Ntuli’s (2002) view on the continued role of divine beings, ancestors, sacred places, people and objects for both urban and rural populations. He states that intellectuals working at formal institutions, who subscribe to Western biomedicine and condemn TMK, actually secretly subscribe to it as well. In Nyanza, a female respondent discussed similar negations of TMK:

\textsuperscript{79} Officer in Charge of the Police Department. 
\textsuperscript{80} Kushirikiana- to cooperate
which are arranged but I cannot go because I have no means. The government has opened it to anyone in the market. In the market people are announcing the use and treatment of these medicines openly. If you take this medicine and mix it with this one, it helps cure this sort of disease... They announce in one market and another, even you were here yesterday, you saw Tuesday market day; you saw them announcing it even in Homabay on the market day. [...] And those announcing them, you know have not planted them (Female TH 49 yrs Suba, Kenya).

Another male respondent in Kenya further emphasized the role of the church in influencing perceptions around TMK practices. He indicated that the common perceptions negate THs and TMK, while at the same traders in TM products continue to commercialize TMK within the marketplace. New opportunities are emerging in urban as well as rural areas, which may create a conflict of interest between THs, harvesters and traders of the products, as researched by Mander et al (2001) and others. We see similarities to the earlier discussed research in the Kwa Zulu Natal Province of South Africa, where THs are increasingly seen to mainly buy raw or semi-processed products from harvesters and traders, and use them to process complex prescribed mixtures to treat their patients (INR 2003). Both the male and female respondents below further discussed the changing and ambivalent status of the traditional healer in contemporary Kenyan society:

There are some civilizations which came, which denied and said there are some things which we are doing which are not good...and those civilizations, it seems, stagnated us in some areas...mm!, But that civilization came in different forms. Then Christianity puts it here and they use it so that it stagnates this TMK culture. Yes! It takes from us our culture and good habits, saying that one who is treating is praying to Satan, but suppose you are here with an STD disease and there is praying, should you not be treated? Or how do we do this thing? If you look at the word of God, He tells Isaya that he should go and get ngou (a plant) and grind it so that the boils can be healed. Secondly, even Jesus when he spit on the floor, and he anoints, he was showing people the means of treating, he anoints on the eyes of the patient and he then tells them to go to the stream to wash their eyes with the water so that their eyes can open. This is the way God was showing us the ways of treating. What I know is that when the rulers came, they had a sort of inhibiting factor in such a way so that you would not be able to know what is behind it...yes, treatment is treatment...If a snake bites you, let me show you and you are treated with medicine of Nya Luo (the ‘daughter/mother of Luo’) and you get healed... don’t you get healed? (Male TH 60 yrs FGD Suba, Kenya).

What I can say is that this thing is something which should be inherited, it should not get lost; even those abroad have not left their traditions, even in Scotland. But for us this civilization wanted to throw us a lot, they wanted us to follow their cultures, yes! (...) If the land can ‘resurrect’ these things, in the future I see that they will go forward well and they will be able to practise TMK and treatment (Female TH 54 yrs Suba, Kenya).
A researcher at KEMRI also discussed the status of the THs and offered the following recommendations:

The approach to take in order to make a visible change is to let the THs treat! We should recognize them, while controlling and regularizing their practice. Their practices should be established and supported countrywide (Female researcher KEMRI, Kenya).

The citations above show what I refer to as the paradox of what the THs term “they come at night and do not like daytime”. Representatives and individuals who live and work within the political establishment, including government and the church, need and want the services of THs. At the same time, however, they do not want to be seen accessing the services. Respondents from both study settings indicated that formal institutions negate the services of the THs during the daytime in the formal settings, for instance in churches. This relates back to my discussion in Chapter 5 on the formal power of the THs and the role they had during the pre-colonial era. During the colonial and post-colonial eras, they had a more subtle and informal power in the socio-medico/cultural health systems in which they were embedded. Horton’s (1988) research indicates that so long as biomedical and African therapeutic knowledge(s) continue to vie for power, the position of the lay therapeutic managers, in this case the THs, will eventually recede (Horton 1988). Although the policy climate for TMK seems to have evolved in a more expressed form, the colonial legacy of negation in the official arena of TMK, and of THs and their role, lives on in the study area.

Some actors (which transcend the societal hierarchy) working within governing structures access TMK in pursuit of attaining goals linked to the acquisition and sustenance of professional success, health and well-being, as well as protection against societal ills, etc. This represents a commitment to accessing, and a dependence on, the subtle and informal power embodied in the socio-medico/cultural health relations - discussed by Agrawal (1995) within TMK and the TH profession in spite of the ‘daylight negation’. I therefore argue that TMK and TH services, which are increasingly sought in this region, could well be entering and engaging within a market economy that provides a contested arena for the ‘gift’, further discussed in Chapter 9.
This paradox originates from what some THs define as the role of ‘civilizations’ which ‘came in different forms’ which denied and seemed to ‘stagnate us’ and ‘throw away good habits’ in some areas ‘like this TMK culture’. ‘Praying’ is defined as ‘throwing away’, ‘refusing’ the work of TMK. The formal church, according to this TH, undermines the work of THs. Historical globalizing processes, including colonial forces and their tenets as well as the church are voiced by the respondents as phenomena whose role and legacy continue to influence contemporary governance actor power relations in transforming, redefining or undermining socio-cultural and socio-economic conditions of daily lives (Acker 2004). As historical transformational processes of social change involving agencies, actors, organizations, governments and social movements continue to have their effects on TMK perceptions and uses, as viewed by Bernstein (2000), the THs voice how these processes have led to different developments in their respective regions.

The respondents lament the hegemonic and unequal dominance between the formal and informal actors and organizations with regard to TMK. Some THs suggest counterhegemonic processes similar to views by Santos (2002) and Gibson-Graham (2006), arguing for a re-engagement with educational learning systems, combined with a reawakening and pragmatic cooperation between the formal and informal governing structures.

7.5 Discussion and conclusions

In my analysis of the empirical material, I identified signs of an extension and further development of the existing cooperation between the traditional knowledge base and mainstream policy development affecting the concerned institutions (both formal and informal). Activities and programmes designed with this in mind could contribute to overcoming some of the difficulties discussed in this study that hinder such cooperative efforts.

The study areas, situated in Mwanza and Nyanza Regions, have evidence of a high prevalence of HIV/AIDS. While youthful populations characterize migration flows to urban and rural spaces (a phenomenon linked to historical processes),
these movements are tied to alternative livelihood-seeking behaviour. The role of urbanization and migration and related implications for TMK in these dynamic processes point to an emerging effective cross-sectoral role of the TH in the formal space. Mwanza Region, with the highest number of THs per region in Tanzania, provides a window of opportunity to address both the problem of HIV/AIDS, as discussed in the empirical study, as well as the albino phenomenon discussed in Chapter 5. State, non-state and regional actors and legislation in concert with legitimate TH organizations are in a position to address both the HIV/AIDS pandemic and the more recent albino phenomenon, which have complex socio-cultural, socio-economic and regional dimensions. However, the new regulations on registration for the certification of THs are making it close to impossible for traditional or legitimate THs to re-enter the traditional healing space. These new regulations may instead favour the ‘new’ commercial healers, some of whom could be those who make a killing by killing albino victims.

The pre-colonial role of traditional governing structures discussed in Chapter 5 depicts the pre-colonial governance of TMK as closely linked with the chieftaincy establishment, embedding the role and power of the TH within the formal arena, which encompassed public health in communities. Their role then within the socio-cultural and socio-economic place may have had a much wider formal space of influence than at any time in subsequent years. Traditional ideologies on public health, with social dimensions 81 that reinforced traditional kinship ideologies (Vaughan 2004), were not encouraged by either the colonial establishment or the post-colonial governments. This nevertheless provided social control over vices and negative aspects of TMK such as witchcraft and sorcery in both the Sukuma and Luo sub-study areas. The abolishment and redefinition of these governing structures provided for an evolving space, defining a more informal public health role of THs and TMK. The contemporary governing structures for TMK, involving sovereign state structures, international and local organizations, are presented with and represent an emerging challenge in positing TMK and the TH profession to address contemporary global issues,

81 Traditional political leaders carried the ultimate responsibility for the communities and the land, including control of witchcraft as a negative application of traditional medicinal knowledge. The powers vested in, for instance, the chiefs in Sukumaland were over the traditional medicinal rituals and they also acted as custodians of the land (Koponen 1988, Brandström 1990).
which will be further discussed in chapters 8 and 9. This includes the commodification and commercialization of TMK as well as the contested arena of IPR.

In my interviews I found that the THs perceived a disdain of their knowledge and therapeutic methods. This reflects a hierarchical and paradigmatic divide between Western biomedicine and traditional therapeutic activities, as discussed in much previous research (Oguamanam 2006, Odora Hoppers 2002, Cotton 1998). It was portrayed in the way actors in the formal power structures, organizations and governance establishment “come at night and do not like daytime”, to access the more informal role and services of the TH profession who provides support for the individual within their socio-spatial context. However, I also found in the empirical material that the Christian missionaries who provided the initial institution of the health care sector in the pre-colonial era in the study area are still anchored here and provide some examples of collaboration between the formal health sector and individual THs and TH organizations.

Globalizing forces continue to define the structure of domination towards new social divisions, including formal political, affluent middle class and elite in the societies of this study, as discussed by Hoogvelt (1997). These societal actors provide some role and space - ranging from a relatively informal role and context to a relatively formal role and context (for some) of the THs. This is the case in the Mwanza study area. In the Nyanza area, even though THs provide services and some have organizations, their role and space are less acknowledged in the formal space than in Mwanza. Counter-hegemonic processes were suggested through expressing a voice to rejuvenate intergenerational learning processes and exchanges at local levels among the youth and local organizations.

I partly attribute the differences discussed above to official policy and governance approaches in Tanzania and Kenya, respectively. In Tanzania, official formal

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82 For instance, the Inter-African Experts Committee on African Traditional Medicine and Medicinal Plants of the African Union, which declared the two decades of 2000-2010 and 2011-2021 as the decades of African traditional medicine, provided a continent-wide strategic framework in collaboration with WHO to promote research and traditional medicinal knowledge.

83 As I discuss earlier, the greatest threat to missionaries and the introduction of new Christian beliefs were TH and the people they referred to as witch doctors and sorcerers, though this empirical study shows that the early approach to replace THs with trained nurses and medical assistants has evolved into a collaboration between the two organizational establishments, the missions and the THs. This is the case with TBAs, which I discuss later.
governance around TMK was established earlier (1974)\textsuperscript{84}, with a first national policy issued in 2000. Today, the anchorage of TMK within the health sector provides a natural platform for engagement by the THs with the formal health establishment (TMK was previously anchored within the cultural services sector in Tanzania). As I discussed earlier, the Tanzanian post-independence government’s brand of socialism had the intention of enabling people from all levels of society to take part in their own governing (Swantz 1996). While preventing factionalism based on ethnicity or religious affiliation and emphasizing national unity, people’s participation in decision-making and self-reliance all focused around the Kiswahili language. I argue that these approaches could have paved way to some early collaborative mechanisms, for instance in officially institutionalizing TMK, that provided space to enable a more natural engagement between formal and informal organizations involved in the governance of TMK.

In Kenya, the development of policy and governance around TMK is on-going and a cross-sectoral approach exists with a number of sectors and organizations. TMK is anchored within the sector of culture and social services, which is viewed as a disadvantage by the THs in Nyanza, who therefore have less space to engage with the formal health establishment. Some respondent researchers in the Kenyan study area note scepticism and negative perceptions surrounding TMK within and outside the health sector, even though the official governing establishment has mandates to collaborate with TH organisations and appreciates the usefulness of TMK and practices. Some of their recommendations include pragmatic approaches to recognizing and enabling THs to carry out their profession, with regularization and control as well as THs organisations and support countrywide.\textsuperscript{85}

The colonial approaches to and view of the traditional midwife as the “arch enemy” (Vaughan 2004) has evolved, as the contemporary traditional birth

\textsuperscript{84} Approximately four years prior to the Alma-Ata Declaration of 1978 – see Swantz et al (1996).

\textsuperscript{85} This is evidenced in issues presented by formal institutions, e.g. KEMRI, which encompasses TMK conservation, cultivation, commercialization and certification options, efficacy, toxicology and standardization, documentation, access and benefit sharing, intellectual property rights, and integration with conventional practice. Some main activities by KEMRI’s traditional medicine department are baseline survey, institutions, researchers and traditional health practitioner associations.
attendant’s role is changing within the socio-cultural milieu of reproductive health. The empirical study in both countries shows the formal training of TBAs in a number of organizations within the health and education sector, where community-based health services link with formal health facilities. This is within a context of relatively high infant mortality, birth rates, and rates of deliveries occurring at home with the assistance of TBAs and relatives. The TBA practice is associated with fertility and childcare, and is anchored in strongly held beliefs embedded in TMK and the prevailing cosmo-visions on general maternal health and antenatal childcare as also discussed by Vaughan (2004). It is seen to have an evolving role within contemporary public health, which captures and addresses socio-cultural health and well-being within the formal and informal reproductive health and education sectors.

This chapter revealed the earlier discussed (Beck 1981) complexities of medical pluralism, which abound in the study area, thus providing evidence of the evolving role the TH plays today in primary health care, in close proximity to both modern urban and rural hospitals and professional practitioners of scientific medicine.
8. Traditional medicinal knowledge and intergenerational learning processes

8.1 Introduction

This chapter analyses how TMK is transferred between generations and examines the dynamics of, challenges to and changes in intergenerational learning processes, against a background of increased migration of the youth to the cities and socio-spatial transformations in land use and increased commercialization. It also discusses other forms of learning, i.e. intra-generational learning and forms of training as adults, which also take place in my study areas.

How is TMK learnt? What are the narratives of THs about their practices of teaching TMK, and how do they perceive contemporary challenges and opportunities regarding these practices? I look at the main modes of learning processes of TMK in the societies studied. I present voices of THs, who define the modes and ways through which TMK is taught and translated through intra- and intergenerational pathways (although the latter predominate the discussions). The learning practices and their relationship to increasingly dynamic societal processes including migration and urbanization are examined, based on the healers’ narratives. As previously discussed, there is research that shows that indigenous and local communities are worried about the high rate of knowledge erosion in the younger generation. Odora Hoppers (2002), for instance, has argued that “The erosion of people’s knowledge associated with natural resources is said to be under greater threat than the erosion of the natural resources themselves” (Odora Hoppers 2002:7). What roles do healers see for the youth in obtaining this knowledge? How do THs perceive the possibilities of sustained livelihoods for the youth in becoming THs?
8.2 Traditional medicinal knowledge learning processes and socio-spatial changes

8.2.1 Learning in place

The empirical material shows a range of learning practices of healers, who worked mostly in their own houses and had their teaching organized spatially according to the location of plants and places of special significance. The healers described the practical ways by which TMK is transferred gradually, over a long period of time, and developed from the knowledge of one kind to different varieties and types of medicinal products. According to Gadsen et al. (1996), the interaction over extended periods of time between generations reinforces knowledge transmission, beliefs and practices through either direct teaching or informal activities in homes or communities. The main approach of training is learning by doing in the home of the healer. This usually requires that the trainee live in-house and have time to ‘sit’ with the healer, most often in the rural area, sometimes at a far distance from primary schools, for prolonged periods of time. The trainee repeats the different healing procedures until he or she is an expert, and it may take years to remember the names of the numerous (sometimes over 200) types of medicine, as narrated by the following two male healers:

How are you teaching the young people so that one day they will be able to take over the work?

Yes, if I can teach someone we sit with him like we are sitting here. Then I show him when the sick are sitting down. Then I show him this medicine one! This one is for asthma milk; it is what is used to treat the asthma patients. The medicine I show him is the medicine for asthma, which you can treat jaasthma (patient with asthma) with. And this one is for jatuberculosis (patient suffering from tuberculosis). This time when we are sitting you can see how his lungs are doing at that time, immediately when we are sitting here. Like the mzungu (white man) when he was given my medicine... (Male TH 62 yrs Gem, Kenya).

You see...in training for traditional native medicines, they say how come you have managed all diseases? Because you have sat on it for years...see this young boy, he has been here since he was a small boy and he is still in training (Male TH 40 yrs Magu, Tanzania).

Thornton defines different disciplines or knowledge groups of THs in South Africa and discusses how individuals are more or less expert in one or several of them. Each discipline, however, must be taught and learnt separately during an apprenticeship period, and it is rare for one person to be expert in all disciplines (see Thornton 2009).
Traditional medicinal knowledge is a system of knowledge that involves harvesting, mixing, grinding, drying, storing, having environmental knowledge, knowing symptoms, diagnosing, training apprenticeship and teaching. In my study areas, as in other parts of the world, it is understood as a system of pedagogy characterized by intergenerational learning, which to a large extent is place-based and related to history, language and social relations. An intense learning exchange process occurs between trainee and healer, mostly in the form of oral narratives and practices in and around the homestead. Whereas oral narratives are central in the training, the THs in my interviews placed little importance on written information. Instead, as also noted by Thornton (2009) and Mwiturubani (2009), a good memory is a preferred characteristic in an apprentice. One traditional healer in Mwalina, Tanzania, described how written information may even be less likely than oral training to be viable in enabling the transfer of knowledge:

The 1,000 to 2,000 trees I've planted... I tell them to go and pick the trees and when they come I show them which and which to mix together. That is how we teach those trainees. If you keep it in the book, nothing! It will get lost (Male TH 62 yrs Mwalina, Tanzania).

This shows the importance placed on “sitting” with the TH in order to learn the plants, rather than “keeping them” in books. Battiste (2002) describes the extensive use of the oral and symbolic nature of traditional knowledge, whose pedagogy is carried out through modelling, practice and animation, “rather than through the written word”. Beck (1981), however, describes a study that found a number of THs in East Africa with elaborate lists of plants and specific uses for them. Among the healers I interviewed, this was not the case; oral pedagogy was the predominant form. The oral nature of intergenerational learning places ethical and moral responsibility on the apprentices and the THs, which also stresses the need for long-term learning. Mirambo (1999) states that oral narratives are in fact an instrument of cultural education, which means that it has a broader significance beyond the actual teaching of traditional medicine.

Sitting with the healer and the learning process result in learning and acquiring one or a combination of specializations. The healers rarely work as, for instance,
only herbalists or only diviners, which also explain the need for prolonged periods of learning. Bonesetters (a category of traditional orthopaedics) can double as herbalists, while traditional midwives also administer herbal prescriptions. The result is that most healers are able to work as herbalists, in combination with other traditional medical practices, including bonesetting, midwifery or traditional birth attendance. The female healer below tells how she herself trained at length to learn a number of specializations:

And before you ‘caught’ the work of medicine what were you working with?

It is the work of medicine, which I started with. I started as a midwife (cholo-literally means- aiding in childbirth) when I was in Class 2. Regarding the words and work of healing my grandma was the one who ‘prayed on me’ when I was a child. Of the ones on my mother’s side there are none I have ‘taken’, but the one of my uncle which I have taken is only chomo (bonesetting). Yes, connecting of the bones. That one my uncle prayed for me, I am a bonesetter, herbalist and midwife. I treat miscarriages, infertility, amoeba, typhoid, awangi, STD, syphilis, Chira, Nga’ maochuo gi yath (someone who has been ‘pierced’ with evil medicine) (Female TH and Traditional Birth Attendant (TBA) 52 yrs Homabay, Kenya).

In my interview material I found that it was more common for THs to take in resident trainees in Mwanza and Magu in Tanzania than in Nyanza and Homabay in Kenya. The practice was also more common in the rural than in the urban settings. Trainees who reside with the THs in the urban setting are most often (though not always) the direct offspring of the healer. When the trainee attends formal education, he or she goes to the healer’s practice after school and undertakes further training during school holidays. In the stories it was clear that the rural-urban mobility and increasing urban practices had affected the traditional way of learning in place. THs expressed concern about this transformation and the changing livelihoods of the younger generation which, apart from less time for learning, some believed could also lead to negative values and attitudes towards TMK:

My son was taught by his grandmother’s sister but he has left this work and does not attach value to it (Male TH 69 yrs Suba, Kenya).

The young people are not vigilant and are not interested. They think it is old-fashioned and only prefer modern medicine (Female TH 80 yrs Rachuonyo, Kenya).
However, there were other healers who held the view that young people increasingly realize the income potential of traditional medicine through observations of the marketing of the products in urban areas. The three male healers below, from both Tanzania and Kenya, increasingly sell their products and provide their services in urban markets, and have noted a change in attitude in the younger generation:

The youth are interested when they see that I have an income; I sell at the market in Homabay and at Rodi Kopany (Male TH 55 yrs Gem, Kenya).

The young people, do they like to learn about this?

Yes, they go to school and they come home and learn, they again go back to school and then come home and learn. So the youth are interested in learning, yes they do come back to learn (Male TH 52 yrs Mwanza, Tanzania)

So you have a boy who has the interest but wants to be a doctor first and then get into the herbal medicines?

Yes he has the interest in these medicines. He has said ‘no Baba I only want to work with traditional medicine in future’. Now he is 18 and in secondary school, Class 2. When he comes he helps me and I send him to the forest to get medicine. When he comes with it he also says ‘Baba you know this one, you grind it like this and mix it with this one’, that is how we use it. So even me I have seen that his ‘heart’ likes medicine. Sometimes I can tell him ‘please go and get me the medicine’ so I send him and then he goes and harvests it and comes with what I sent him for, and I show him how to do the treatment (Male TH 62 yrs FGD Homabay, Kenya).

The first of the male healers above observed that when young people saw that he could make a living from marketing the products, they showed a keen interest in studying traditional medicine. For the youth, the potential income from selling the products in urban areas represented a livelihood opportunity in a context of scarce employment opportunities. This interest faced challenges, however, as the learning processes themselves require a spatial setting where the trainee can ‘sit’ with the healer for prolonged periods of time and have access to recollection areas of medicinal plants. The narratives of healers expressed how in tougher socio-economic conditions in both rural and urban areas it becomes more difficult for THs to provide housing for trainees and, obviously, school attendance makes time more limited for a learning practice which takes many years even when it is continuous.
The Kenyan and Tanzanian governments’ policies of free primary education have provided incentives and opportunities for school attendance in both study areas, which has led some THs to promote the combination of TMK with formal primary education. The healers in both rural and urban settings highlighted the importance of teaching indigenous knowledge to the youth, but they also stressed the challenges to TMK related to migration and rapid urbanization.\(^{87}\)

8.2.2 Being sent

In addition to the practice of learning in place through ‘sitting’ with the traditional healer, the respondents detailed further aspects of the ways they themselves had learned TMK and how they in turn trained new medicinal practitioners. ‘Being sent’ was talked about as a widespread, practical way of learning the characteristics and availability of plants and as a form of learning by doing, which is at the core of TMK. The trainee is sent to specific destinations to collect the products. Being sent is emphasized as crucial for obtaining the knowledge, but is also a form of payment from the trainee to the healer. The trainee is regularly sent to the forest or bush to collect and harvest medicinal plants and bring them back to the homestead, which can be both time-consuming and tiring:

First if you want to know work you should be a person’s messenger. She says, go and dig this medicine, you see this medicine... go and look for it and bring it to me... so you do it until you know it (Female TH 55 yrs Gem, Kenya).

Yes at ten years they taught me, my parents taught me. They teach you when you are small like this boy (points at his son in the room). They send you and you ‘follow’ the medicine. I was still small. My father also got this thing from his own father. My mother’s grandfather and father were also traditional medicine men. So the education was twofold, from my father and from my mother (Male TH 62 yrs Mwalina, Tanzania).

I can tell him, please go and get me the medicine, I send him and then he goes and harvests it and I show him how to do the treatment. I tell him ‘you child, this person’s leg is swollen, I want to treat it. Go and get me medicine’ so then he asks ‘which one is it’? Then I show him which one, and when I have sent him, he brings it. When he has brought it, he asks Baba how do you do this’?

\(^{87}\)These findings relate to Bourke’s 1994 scholarship on Aboriginal contexts, where continuity of knowledge learning was strived for while at the same time uneven power relations between the periphery and centres within the national context were still real and present. The agency of TH is embedded within a contested arena of learning and education systems in my study areas, which are characterized by peripheral positions within the national contexts of Kenya and Tanzania.
Then I show him. We do it like this, if it is ground, it is done like this, and I repeat to him and so on. Then he comes with what I sent him for! (Male TH 62 yrs Homabay, Kenya).

The traditional healer shows the trainees the exact character of the medicines, explaining what they cure. Being sent as well as in-house repeated demonstration and practical work with patients are central to how the trainee receives the education. Without fees paid for the education, as a form of payment the trainees contribute by being sent to harvest the medicine, helping on the farm and providing other services within the homestead:

Is there any payment they give you?

No they do not pay me anything. So what benefits will you get from showing them? My interest is what I give them. They acquire the legacy from me. I want them to acquire the knowledge from me (Male TH 63 yrs Homabay, Kenya).

Otherwise they have no payment. Those who are unable, they farm. They help build the patient’s house, clean the environment. Those who are unable to pay work instead (Male TH 60 years FGD, Mwanza, Tanzania).

According to the narratives of the healers, the teaching, transfer and processing of TMK today have both similarities and differences with the ways the older generation learned their practices. Some major differences relate to the abundance of plants closer to the homestead in previous times. The geographical distances have increased to places of harvest as well as to beneficiaries, which means both that trainees have to be sent longer distances and that new plant preservation techniques have developed:

It is not different, but the style in which I use the medicine is different from the old time, the system is different. You know, the old people used to dig the medicine, put it in a pot and boil it and then people drank it. I take the medicine and pound it until it is very soft, soft. Then I spread it in the sun and it dries and I use it in powder form. It means that in powder form it can be used for a long time. It can last longer while the boiled one has a short shelf life (Female TH 55 yrs Homabay, Kenya).

These days getting the medicines is hard. We take the bus a long way or give someone money for transportation to go to the forest. There are a lot of problems getting the medicines these days. We get them with difficulty. We have to pay a lot when we harvest the medicines (Male TH 65 yrs Arusha, Tanzania).

88 I analyse this further in Chapter 9, where healers discuss the effect of longer distances to harvest TM products and environmental changes in the context of the commoditization and commercialization of TMK and products.
The older healers thus harvested and boiled the medicinal plants and consumed the liquid or the boiled leaves. Today, the healers use drying and pounding techniques, which provides a longer shelf life and eases transportation. Increased migration to the urban centres and other regions, which are situated far from the locations where the medicinal products are harvested, has necessitated a change of preservation techniques to accommodate a longer shelf life for the products. Mander’s research in Kwa-Zulu Natal shows that THs mainly buy raw or semi-processed products from harvesters and traders, and use them to process complex prescribed mixtures to treat their patients (INR 2003). The steady decrease in availability of the medicinal products, together with the difficulty of sending trainees long distances, also necessitates preservation. Healers in both Mwanza and Nyanza described how the older generation used to cultivate plants close to the homestead to help in accessibility and in teaching trainees and family members, combining the gathering of medicinal plants from the wild bush with planting them closer to the homestead. Some of the younger and older healers do not cultivate plants close to the homestead at all, but respondents also described how they had to seek permission and pay in order to be able to harvest from other clan lands89.

Among the Luo a man’s plots are divided among his wives, and if they are deceased the plots pass on to male children, with the senior son receiving the largest portion (Ochieng 1997). With the socio-economic and socio-spatial changes, land allocation and accessibility have changed and land has become scarcer and commodified90. When clan land gets overcrowded, there is further migration to found new polities elsewhere (Ochieng 1997). This indirectly or directly influences harvesting and cultivation practices of traditional medicine, and the empirical data revealed that this was particularly the case in the Nyanza context, where scarcity of land is more apparent than in Mwanza.

89 See my discussion in Chapter 8 related to planting, harvesting and paying fees.
90 See my discussion in Chapter 5 on changes in land policy in Tanzania and Kenya.
8.2.3 Learning practices and tensions between generations

While being sent is presented as a central form and important way of learning TMK, several narratives pointed out how particularly this aspect of intergenerational learning practices was becoming difficult to uphold. Explanations were partly expressed in terms of tensions between generations and changing family structures, with some healers complaining about a lack of will on the part of the youth, as well as a lack of a system of control over children:

The youth today do not agree to be sent (Male TH 60 yrs Gem, Kenya).

If we can find a way in which we can put children so we can teach them, the small children like this one (points to his son). He lived with his grandmother...eh! She used to send him, he knows a lot about this thing, but then when he left this thing he left it as useless (Male TH 69 yrs Suba, Kenya).

The quotes show the perception of some healers that the youth are not willing to be sent, and also may abandon the teaching after having been trained. The characteristics of being receptive and obedient were no longer seen as widespread among the youth. These healers were afraid that only few would be appropriately prepared to have these ‘stories’ passed on to them. This has consequences in relation to the continuance/sustenance of the intergenerational learning processes. In the context of “fear” and “loss”, which Ntuli (2002) discusses, I interpret these healers’ perspectives as fear on the part of the ‘knowledge keepers’ of a loss of mutuality and reciprocity between generations and regarding how TMK could live on. The separation in place of the youth from their parents/grandparents due to prolonged periods at school may lead to discontinuity in intergenerational learning pedagogies. The interdependence of the societal processes in communities, described by Ntuli (2002), which I place in the context of the healers’ practice and the learning apprentice, encounters and embodies a conflict, which translates into what Cole (1996) describes as “prolepsis” on changes in relations and social values between the young and old. The study shows that the processes of ‘being sent’ contain dynamism between the apprentice and the THs that involves mutual and reciprocal relationships.

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91 Fatnowna et al. (2002) and Bourke (1994:135) discuss the context premised on the legacy of colonialism, which involved the spatial dislocation and forced separation of children from parents that caused a discontinuity in intergenerational learning pedagogies among Aboriginal and First Nations in Australia and Canada, respectively.
during the entire learning period and beyond. The youth, however, in relation to changing societal dynamics, are increasingly mobile and presented with alternative livelihood systems that contest TMK as a profession to be learned.

A changing extended family structure translates to the youth spending less time with the elders, as their education, livelihood and for further opportunities in life engage them in diverse spaces and places away from their home areas. While kinship and intergenerational relationships are central in providing coherence in situating governance structures of these learning systems (Coombes et al. 1983), migratory tendencies, urbanization and emerging livelihood strategies are unarguably important for the youth and their place relations. This, coupled with a demographic shift, have has a combined effect of an increasingly elongated space between the younger and older generations which may pose a threat to, and lead to the loss of, mutuality and reciprocity between generations. McGrew’s (2000) argument on globalization’s role in transformational processes in the spatial organization of social relations and transactions invokes the impact of interactions, movements and social networks – and the diffusion of new ideas and behaviours while enabling learning and influences to occur through social interaction (Lindström and Munoz Franco 2005). I see an evolving exercise of power that the youth increasingly perform in defining their space and place in their overall social development, and in relation to livelihood strategies such as learning TMK and acquiring a healer profession. This is shown in, for instance, their approaching formal organizations for learning opportunities.

Even though learning between generations is crucial, intra-generational learning of medicinal knowledge also takes place among the Luo. This is described by Geissler et al. (2002), and I also found it in my material. One example of intra-generational learning was when an elderly female healer shared TMK with her elder sister:

The medicine for the STDs, you can go and get it at ka nyamera (my sister’s home). It is behind the bush, there’s plenty there. That’s where I came with it from. She treats many other diseases, her own diseases that do not look like mine (Female TH 80 yrs Rachuonyo, Kenya).
The above is discussed by Cavalli et al. (1982), who state that this learning and transmission of knowledge may also occur between individuals of the same generation, irrespective of their relationship (horizontal transmission). This kind of learning is different from when young children are taught by elders. Research has also shown that vertical transmission tends to be highly conservative whereas horizontal transmission may be of another character. The quote also suggests that the two older healers had different knowledge of TMK and could therefore learn from each other. The respondent took TM products from her sister’s home to her own marital home, which underscores earlier discussions on the role of married women in exchanging TMK within the exogamous system of Luo marital traditions. Spatial differences may mean differences in ailments; thus the importance of exchange of knowledge between different locations.

8.2.4 Ritual places

In their stories, the THs placed central emphasis on the correspondence of their learning with invisible spiritual entities, and prayer and ritual form an important part of trainees’ education. One “prays to the ancestors for guidance to find the medicine”, as one healer expressed it. These are ‘found’ through dreams ‘sent’ to the THs, as seen in the citations below:

So it is spiritual. And the dreams. It’s a very very accurate way of getting the actual medicine, because it is spiritual (Male TH 78 yrs Homabay, Kenya).

When I dream of something it happens, then when I am shown in the dream to take a certain medicine to mix it with this other one and then I give it, it is going to help (Female TH 55 yrs Gem, Kenya).

I was taught through dreams; I was shown this and this treats this...I was even told after a month this and this person will come and you will treat him in this way so I was shown through dreams (Female TH 36 yrs Magu, Tanzania).

My father’s brother was treating; I used to sit with him. He treated people a lot after he came from the war. When he went to Tanganyika he treated people there and then he died there and they buried him there. So after he died those juogi (spirits) descended on me. When they had descended on me I started to harvest medicine. Because I used to sit with him like you are now sitting with this mama (points to interviewer sitting next to assistant). So I started in my head, me, no one taught me. So what used to happen was when I dreamed about medicine, when I took it and gave to someone he got well. That is why I
am treating. Me, no one has taught me, some of the medicines I learn through experience (Male TH 59 yrs FGD Homabay).

The last citation implies in my interpretation that this healer draws much of his knowledge from tacit knowledge when he mentions 'no one taught me'. Tacit knowledge, which has a central position in TMK, is deeply rooted and learned through experience, it emerges and flourishes while not being put into exact words, but has a real presence and is a central feature of his profession and practice.92

Larger rituals were also presented as an integral part of a healer's work, and these are carried out periodically (bi-annually; every three years). Mirambo (1999) states that a firm belief among Sukuma healers is that fate is determined by shing’wengwe and shishie’we, that is ogres and spirits (Mirambo 1999). The knowledge of rituals is taught during the learning period, and the specific ritual differs from person to person. Some ritual ceremonies use staple fodder and animal products (milk, ghee, sorghum, millet) and follow a special dress code for all participants that may be specific depending on the training. Almost always, a special tree has been chosen as the venue for the ritual ceremonies, usually situated hundreds of kilometres from the healer’s home. These trees are often not available locally due to deforestation and environmental changes; In other words, the specific tree species are rare. These sacred places are visited to acquire spiritual power, perform rituals and collect medicines. This resonates with research arguing that the use of plants in traditional medicine does not depend exclusively on their pharmaceutical potency as herbal extracts but rather on their religious significance (Oguamanam 2006). It also stresses the definition of TMK as unique to places and embedded in community practices, relationships and rituals (Tanzania Gateway 2010).

Studies have shown that ritual places are inherently tied to those specific landscapes where ceremonies are held, in spaces where sacred places define spiritual connectedness (Morphy 1995). Frawley (1999) further discusses the

92 Battiste et al. (2000) argue that indigenous knowledge transfer is seen as a living process to be absorbed and understood, while learning is viewed as a lifelong responsibility that people assume to understand the world around them and to animate their personal responsibilities. Ntuli discloses, 'The aimed outcome of such a learning system is a prize in the form of a people-centered individual' (Ntuli 2002:61).
interconnectedness and an understanding of place and space as part of TMK and its related mythical significance\(^93\). In my study the healers talked about how they travelled great distances to visit important sacred places. One example of this is a healer who travelled with trainees approximately 700 km, from Magu to Tanga Region in Tanzania to perform the ritual. As the tree was situated in another region, there had to be an agreement with the local village council to allow the visitors to carry out their work:

The tree I use is called *Mzange* tree but this tree is not found here. It is found in Tanga. From here to Tanga is like how many kilometres? It is even up to 1,000 kilometres...! If you pass Nairobi, it’s ok, Arusha, then you go, Arusha, Kilimanjaro, then you enter Tanga. That place, you then climb in another vehicle. I take three vehicles! The fare now is 100,000 TSh (USD 90) for one fare and that’s just only fare for one person. And you do not go alone; we can go either three or two persons. That is just going. You have not ‘slept’ - hotel expenses, you have not eaten, just one person. 200,000 TSh times three people. And if the rains fall, the vehicles do not go and you can sit for days, two, three, while it’s near. To reach there and to find the natives of the place and agree with the village elders on the use of their land! The journey involves things like that (Male TH 40 yrs Magu, Tanzania).

If you want that tree, to dig it, first you have to perform certain rituals, sacrifices. That is *Mzange* tree, that one...eh...! Yes *Mzange* or *Nyuguyu*. If you do not perform sacrifices then you cannot dig it, if you cut it, it cannot be cut down or it ‘bleeds’. If you dig it anyhow and go to try and use it for treatment it does not heal! (Male TH 63 yrs FGD Mwalina, Tanzania).

Now the trees are quickly disappearing. *Nyuguyu* is like that, *Nyuguyu* is a sacred tree. Rituals are done near the tree. When we are going to the tree to go and do the *matandiko*, there are different ways. You can wear a black dress, a traditional container like the one we saw, you go with sorghum, it depends on the individual, and how he was taught by his teacher. Each person is taught in his own way, it differs in how to use it in the field, which you were taught, the field which you know, or how you received it from the ancestors. The tree needs something to get that power, like it is a celebration, to celebrate. Like if a big person comes, you slaughter a sheep. When he comes he is celebrated, he is a big person, so the tree is a person, it is a living thing, it has to be nourished and celebrated, it gets happiness...I think you have understood what I mean (Male TH 89 yrs FGD Mondo, Tanzania).

The rituals and ceremonies in specific sacred places were a more important function in Mwanza than in Nyanza. Mirambo’s (1999) research has highlighted

\(^{93}\) Frawley’s (1999) scholarship draws on the Australian Aboriginal indigenous knowledge and its related learning as place-based and related to history, language and social relations while viewed within a place with specific landscapes, landforms and connectedness dimensions.
the specific importance of this among the Sukuma, in which she describes the
Sukuma’s song and dance within oral narratives that come naturally and are
significant to them in rituals, ceremonies, childbirth, death, work, etc. (Mirambo
(1999). The stories of the healers expressed that in both contexts this form of
training is becoming increasingly rare for the youth, given the long distances to
the ritual sites, which involve many days’ travel. This decline in ritual activities
surrounding the learning processes and knowledge of TMK and how the youth
perceive their role is exemplified in a study in the Usambara area of the Eastern
Arc Region of Tanzania. Through a participatory assessment survey within
communities, Kweka (2004) discusses the major causes of the erosion of ritual
activities. He argues that due to changes in attitudes concerning religion and
“civilization”, most members of the community, especially the youth, have very
weak beliefs in such rituals.

8.3 Mobility and health knowledge diffusion

In contrast to the THs who narrated how they trained or inherited the gift at a
young age, there were those who described how they had acquired medicinal
knowledge through their own illness, and also how this training started later in
life. Due to the cure of a prolonged ailment, some had chosen to become
practitioners themselves after a period of training with an older TH for up to
close three years. The suffering itself was seen as part of, and even a prerequisite for,
the learning process:

I was hurting hurting! After I was healed I started to treat others one by one
(Female TH 36 yrs Magu, Tanzania).

I lived in Zaire. I was sick, the disease of asthma. So I lived there for a period
amounting to two years. Then I read the medicine and came back here to
Kenya. I decided to continue working with it (Male TH 60 yrs Gem, Kenya).

Medicine? How I knew it? Yes oh I started medicine, knowing it, a long time
ago. It descended on me; first of all I am the one who was very sick. It was
making my son and me sick, the Chang’aa! (locally brewed alcohol). Yes we
were drunkards and my son he liked a lot of noise. The noise brought us a lot
of problems. Then the ‘mother of the house’ (his wife) looked for a way to help
or someone who could bring help for us. So she went and we got help. So
these days it is tea that I drink. Alcohol, I do not drink. Even my son it is
cigarettes that he ‘drinks’ but alcohol he does not (Male TH 55 yrs Gem, Kenya).

The stories revealed that becoming a TH at a later age, sometimes through one’s own illness, frequently took place outside the trainee’s home area, and often even outside his or her country of origin. The third citation reveals aspects of TMK in a social context, with the healer explaining that he and his son were drunkards, which can be a chronic social problem in the local context, which he terms noise. ‘Help’ was obtained, with the knowledge of the ‘mother of the house’ (the healer’s wife) of TMK also coming into play. This citation exemplifies the social context of TMK and the role a healer plays in primary health care, which also embraces other social problems related to well-being not directly regarded as illnesses in the conventional sense. I further discuss this in the next chapter in relation to the THs’ roles and status in society.

After graduation, a number of trainees return to their original homes, sometimes in other countries, and set up village hospitals. This phenomenon was talked about among the healers in Tanzania more than in Kenya:

We have given training to many who now have their own villages, more than ten persons; they are now in Dar es Salaam, Musoma and Tarime, and also Kenya (Male TH 54 yrs Magu, Tanzania).

When they graduate they do well. They develop well after this and they do very well, in fact some have big villages like this one of mine after they graduate (Male TH 68 yrs Mwalina, Tanzania).

This diffusion of health knowledge took place because of the migration strategies of trainees, and it was not unusual to hear stories of trainees relocating to other parts of the country or abroad after their graduation. Trainees migrated temporarily to undergo treatment and/or learn TMK, with the aim of returning to their home region to practice their trade there. In conversations with older THs, they expressed how the TMK is not ‘owned’ by them but is rather given to them by different venues as a gift from a higher deity, which they in turn are to give to

\[94\text{ Noise can be interpreted in a context of disturbance within the family and community and a lack of well-being of the individuals, caused by actions due to alcoholism, which the TH explains was affecting him and his son.}\]
others. Spiritual aspects of the gift as well as the role of the healer as an avenue or its disperser were stated by all the healers I interviewed. The dispersion of this knowledge through the mobility of the newly trained healers was not entirely without tension, however, as doubt could sometimes be raised about the intentions or character of the graduated healers, as will be discussed below.

In most descriptions of the diviner in African society, it is the diviner who detects the cause of a disease and follows up with treatment on the basis of supernatural premises with the aid of herbal medicine (Beck 1981). The healer is understood to be the “kind of person whom God, via nature, put in [a] position to heal” (Alum et al. 2009). The gift he/she besits is to be used to help cure ailments and societal problems. It is the duty of the traditional healer to act as a medium through which this gift is shared with individuals within the society who may need it; thus diffusion of the knowledge is central. The diviner, as described by Mbiti (1991), in past and present African life was credited with the gift and the ability to communicate with the spirits responsible for family and community, and was the authority to decide what had gone wrong and what causes a particular illness, pain or bad luck. However, THs should only teach TMK to trainees whom they perceive have a ‘good nature’, who can ‘do good’, and who have empathy for their fellow human beings, which will also lead to new discoveries in the medicine:

You see someone whose heart is good (...) You do not just give it to anyone... if you see someone who is hurting then you have sympathy and want to help him so then a lot of discoveries can come out of that medicine for you ...(Female TBA 55 yrs Homabay, Kenya).

Those who I am giving the system, they may in the future provide even better ways of treating, perhaps they will be able to treat even better than I do, they may improvise (Male TH 67 yrs Homabay, Kenya).

Some THs perceived that if they trained the wrong person he/she might be dishonest and take the knowledge and sell it for private benefit in other locations. The person may move and “take their knowledge and their customers” and use it for their own interests, indicating that “some could even use it to harm others”. According to some respondents, there are a number of herbalists who may want to replicate what they do, claiming knowledge of the medicines they have. THs
linked this negative knowledge diffusion to out-migration and commercialization, with potentially negative effects on patients:

Adding knowledge to someone as it was added to me, I still find it difficult in one way. There was someone with a good idea and they took him and gave him a job. Then it happened that he was sent away from the work. Then you know that those people have remained with all his ideas and then they take the customers that you used to get (Male TH 56 yrs FGD Gem, Kenya).

Many herbalists, they think the medicines which I have they should also have, so they take them...at times they give the wrong medicines and overdose them, which can injure people (Male TH 62 yrs Homabay, Kenya).

These two respondents’ views concern withholding knowledge due to a fear that it will otherwise be exploited commercially or used dangerously. Mashelkar (2002) identified individuals in indigenous communities involved in learning processes who viewed themselves as informal creators or innovators, thus possessing knowledge they wanted to protect in a similar way as expressed by the respondents above.

8.3.1 Mobility of the youth and fear of sorcery

The discussion on sorcery arises in the empirical data particularly within the context of ethics as well as socio-cultural and socio-economic problems. In all interviews this negative phenomenon was mentioned and vehemently criticized by the THs and authorities. During one of the interview sessions, the district administration’s office in Magu asked me to assist them in identifying and curtailing sources of sorcery, which is still a widespread phenomenon and a challenge in their administrative area. In the citations below, the fears were particularly related to the mobile younger generation’s uses of TMK. Dynamic changes in societal processes in the communities linked to migration and urbanization highlighted the role of parents, who according to some healers sometimes feared and criticized the healers’ work:

Parents think it is negative and they have fear (Male TH 55 yrs FGD Suba, Kenya).
Some fear and accuse the young people of learning how to bewitch and kill people (Male TH 52 yrs FGD Gem, Kenya).

The family and household need to have a consensus on whether the TMK can be taught to the youth (Female TH 59 yrs Gem, Kenya).

Since I started this work I have never indicated that someone has been bewitched by anyone. My job is to treat people. My work since the beginning is to see the illness and to treat the patients, or to take them to the hospital. Recently someone came here and said ‘he has got problems, he has been bewitched, and how can you help’? I told him ‘there is medicine’ and did not tell him he had been bewitched. Because God, He gives the disease (‘He makes people hurt’) and also He makes available the medicine for healing, so he then asked if there was medicine to help him, if it was available, I told him that that medicine was available (Male TH 68 yrs Mwalina Mwanza, Tanzania).

All the THs in the study distanced themselves from witches and wizards, including the use of human organs in their practice, as is the case in the albino phenomenon in the region, which I further discuss in the next chapter. One healer said that THs are understood to combine their powers with herbal preparations to treat illnesses and carry out good deeds, including casting away evil and identifying witches.

TH thus expressed concerns in relation to knowledge diffusion through increased migration, but there were also those who saw both livelihood opportunities and possibilities for closer interaction between TMK and ‘modern’ medicine in light of increased urbanization and commercialization. Some healers spoke of future plans to expand the premises for patients in both rural and urban areas. Particularly in Tanzania, it was common to mention plans to cultivate medicinal plants on land already purchased and acquired for this purpose. Some healers saw the way forward in finding new ways of combining TMK learning with formal education, thus bridging rural practices with urban educational and market opportunities. These healers looked to the future with optimism, and when two rural-based THs were asked about future initiatives and their profession in the urban setting they replied with mixed but optimistic narratives. One older TH, when asked if he travelled outside Tanzania, joked:

No! Before, I did not trust travelling and was afraid to travel with the metal airplane because I thought there were no toilets so that I would not be able to
eat for two days! But now I know I can travel to other places and work with beneficiaries to support this work (Male TH 70 yrs Missungwi, Tanzania).

Another older TH in Tanzania who had a village hospital was in favour of travelling to the urban centres to participate in work that is becoming increasingly widespread in the urban setting:

You know I respect visitors like you, who have come from the town. You know, this year I have received six free air tickets to travel to Dar es Salaam to work with people there. I did not use my own money even a little to Dar es Salaam. If you do not follow lies and are honest, this work will become more and improve for the better, and God will bless your work (male TH 69 yrs Magu, Tanzania).

THs, who have a central role in and responsibility for the health and well-being of the community and whose authority lies in determining the cause of illness, pain, bad luck and other societal problems, indicate that the diffusion of TMK through the gift within the community is predominantly to and through persons who have certain required characteristics, as discussed earlier. The ethical dimensions of TMK are re-emphasized here by an older rural-based TH. Apprentices who learn TMK after prolonged illness are usually older and, as will be discussed later, have important evolving attitudes towards the gift that are linked with their acquisition of TMK at a later stage in their life course.

A concern expressed by all THs was the importance of diffusing TMK only to the right individuals, while younger male urban-based healers in Homabay increasingly view and mention their property rights within their knowledge on TMK, as we will discuss in the next chapter. Some concerns about the role of sorcery and negative practices, which were vehemently condemned by all THs in this study, indicate that the youth, who are increasingly migrating to urban and other regions, could be subjected to this phenomenon, although their interest in TMK is seen to be more as a livelihood strategy.

The healers view the future with some optimism, and discuss initiatives including the cultivation of medicinal plants, combining learning TMK with formal education and rural-based THs increasingly practising their profession in the urban space, thus bridging rural practices with urban educational and market opportunities.
8.4 Rural-urban tensions and interaction between TMK and Western knowledge

While expressing concerns about the future generations, many respondents nevertheless stressed that youth are interested and wish to practice as THs. I found learning processes that combined formal medical education with TMK, and some THs, themselves possessing a formal Western education, who encouraged their offspring to complete their education before pursuing work with traditional medicine:

Are the youth interested in learning about traditional medicine? Very much! The moment they learn this they want to continue. I say they should finish school first, and to those who have finished I teach the treatment (male TH 52 yrs Homabay, Kenya).

There is another one who tried to read, and recently went to the college of medicine. Now he has finished and is at home. You see, he has inherited (male TH in 55 yrs FGD Homabay, Kenya).

I usually teach both modern medicine and traditional medicine. People come and I also refer to the hospital. Every two days they come and I give advice (male TH 69 yrs Suba, Kenya).

In my study area I thus found several stories in favour of medical pluralism\textsuperscript{95}. I also observed some cases of practices of medical pluralism during my fieldwork. Some Sukuma healers explicitly recognized the benefits of modern medicine, and several of my respondents suggested that there are certain ailments which only a traditional healer can cure, yet there are other sicknesses which a modern hospital can more readily heal with technologies like intravenous fluids and store-bought medicines. Pragmatic considerations were common, but forms of true cooperation between the two systems were rare. In their narratives, my respondents shared the view of scholars such as Agrawal (1995), who has argued that indigenous knowledge and scientific information should be combined in order to solve emerging problems of a practical nature. In Chapter 2 and 3 I discussed research on how, for instance, the daily life of Australian Aboriginal people is characterized by a continual complementary practice of indigenous and

\textsuperscript{95}In this study I understand medical pluralism as the consultation of both traditional and Western medical practices (Langwick 2008).
Western health and mental health care to various degrees in different parts of Australia.

In the healers’ stories, the interactions between traditional and modern health systems were related to rural-urban inequalities and did not take place without complications. I found a few cases of close cooperation between healers and modern health systems, such as when the TH referred his patients to hospitals, and one practitioner received patients from the hospitals and organized a transportation system to facilitate the interaction between his village and the urban hospital. Swantz’s (1991) discussion on the diviner in Tanzania and his collaboration with the Western medical establishment resonates with the above collaboration both among waganga\(^{96}\) (Swantz 1991) as well as between the waganga and the modern hospital. Previous research by Beck (1981) also did not identify a conflict between TMK and modern hospitals:

The first concern for the diviner is not what causes a particular disease but who caused the illness that befell the sick person and how the patient can be protected in the future from becoming again the victim of evil forces. When the question has been answered, the patient may be treated by ‘magic’ and herbal medicine dispensed by the diviner, or he may seek help of a herbalist who does not do any divining, or he may seek help from a modern hospital (Beck 1981:66).

In contrast with this positive interaction, facilitated by practitioners’ knowledge of both traditional and ‘modern’ medicine, there were nevertheless also pessimistic views among THs about the future of TMK and the role of the younger generation in endorsing it. The growing disenchantment with farming as a way of life has caused young rural people in both Mwanza and Nyanza to actively diversify into non-agricultural activities. Rural-based TMK is not perceived as a viable long-term livelihood strategy for the younger generation, but some THs envisioned a strategy for young people to become healers by way of combining formal medical studies in the urban area and a return to the rural area for training as a TH. Two of the younger respondents had sons who were currently attending urban formal education and intended to complete it before continuing working with traditional medicine in the rural setting. Another

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\(^{96}\) Waganga–Plural for Mganga – in Kiswahili literally means doctor–meaning here is a TH.
respondent’s son, who was 18 years old, had decided to become a doctor in formal medicine and thereafter practice as a TH. The healers testified that it has become more common for younger THs to be trained in both systems. As mentioned, one of the respondents told me how she, as a traditional birth attendant in Nyanza, had trained her son and how he now practiced together with his wife at a large hospital in the region.

Unemployment, including large youth populations in urban areas, has meant that some youth actively seek opportunities to become healers. Researchers I interviewed at the Traditional Medicine Department at KEMRI in Nairobi told me they had noticed a growing number of young people in search of opportunities and livelihoods in the field of traditional medicine:

The lack of livelihoods and money to sustain their living, with high unemployment for the young people, it could be a danger with regard to genuine THs. Young people meet me. They lack employment and always ask me ‘where can I go and train as a traditional healer? (KEMRI researcher).

Earlier in the chapter I discussed how youth viewed TMK in a positive light, with an income potential of, for instance the marketing of traditional medicinal products. It is therefore conclusive that in view of the discussed ongoing collaboration between THs and the formal medical/research organizations, further developments could occur, if an improved resource allocation and a clearer policy mandate and climate are in place. Researchers and THs mentioned this repeatedly during the interviews.

8.5 Discussion, perspectives and conclusions

The concerns the THs express in their narratives reaffirm the approach emphasized by WHO and government policy, that it is important to reverse the erosion of the centuries-old TMK and practices. Traditional medicine should be given a place, and THs should take responsibility for the culture of its utilization. My interviews contain stories about how the role of TMK in the past was very central to community health care and that it continues to be significant, though significant changes are seen, for instance, in preservation techniques like
pounding and drying, which accommodate longer shelf life for products that are increasingly being harvested at longer distances.

The THs interviewed in this study described how environmental pressure, migration of the youth and socio-spatial changes in the study area over the past three decades have created new challenges for learning TMK practices. The healers related how the practices of learning in place, being sent and visiting sacred places have increasingly come under pressure. Some were concerned about negative values regarding TMK in the younger generation, while others stressed the will of young people to engage in training to become healers. This study shows that the youth’s keen interest in learning TMK is seen to increase when they view improved livelihood possibilities of THs due to the commercialization of medicinal plants.

I found that during fieldwork it was not uncommon that there were no trainees in the homesteads of THs. Many young people lack interest in learning TMK and do not approach them often, but in both study areas there were THs who had trainees who were positive and interested in learning. If assistance was provided, on strategic and practical levels, a number of THs mentioned that in future they would be able to organize more training for interested youth. The study reveals that the youth who receive this TMK would be better equipped if TMK learning were combined with that of modern medical knowledge, as three younger urban male respondents stated that this might allow them to improvise some of the ways in which they treat. The incorporation and assimilation of indigenous local learning into Western pedagogies are discussed by Bourke (1994) and McConaghy (2000), who explore a decolonizing and rethinking of education and learning for indigenous pedagogy in some Canadian and Australian contexts. This study highlights attempts by THs to encourage ongoing approaches in education for the youth in conventional medicine followed by, or in parallel with, TMK learned through traditional pedagogies employed by the TH themselves, as seen in the learning processes in this study.

Some of the respondents, who were themselves educated, pointed out the missing link between TMK learning processes and the formal education system. My study
showed a strong influence of modern education in affecting the perceptions and access of the youth concerning TMK. With this opportunity, the youth who attend modern education (which is free and mandated by law in both countries) have limited time, if any, to learn TMK. The future of TMK learning processes may be limited unless incentives are put in place for the youth regarding their future livelihoods. The younger generations could be empowered through awareness creation. Samba (2003) suggests that, depending on their age and level of education, schoolchildren should be empowered to recognize herbal medicinal plants, name and describe the five most common diseases in their communities, and cite at least one treatment for each of them (Samba 2003). This argument is presented and discussed by the THs, who indicate that for the long-term sustainability of this resource and learning system, a concerted effort is required within the formal education system, where most youth and young minds are engaged for a good part of the school year.

The colonial genesis and the legacy of colonial education were profiled by ideologies framed with a “fear that education to read and write would result in more harm than good and would lead to a demand that Africa should belong to Africans” (Koponen 1994:500). Odora Hoppers (2002) argues that in Africa, colonial science and education is knowledge about Africa. The problem today is how to make it knowledge by Africans for their own collective promotion and development. This is a context in which TMK is barely tolerated and exists in subjugate deference to a mainstream form of knowledge that is promoted as the only way of seeing, and the only tool by which people can receive accreditation and a licence to be (2002:14). The Sukuma and Luo youth livelihoods are increasingly merging into circumstances that place lower value on their TMK. Under this pressure, according to the THs, traditional knowledge of medicinal plants is starting to disappear, with little to take its place. Western medicine and knowledge are commonly promoted for young people, but too often without providing the means to gain access to them (Beyer 2009).

The interaction between THs and the modern health system varied in the different places of the study area, with examples of close and uncomplicated cooperation in some places and little or no interaction in others, as seen in
Chapter 6. In both study areas the THs generally stated that there are some signs of a new awareness and popularity of TMK, but the younger generation generally does not take TMK as seriously as the older generation does. Also noted is that as well as being ancient, TMK is modern in these communities as it reacts to changes and evolves in a learning context (for instance in relation to HIV/AIDS mitigation, as seen in the previous chapter). TMK is a result of experimentation and research, trial and error, providing room for innovative local knowledge learning in local practices and systems, even incorporating external knowledge based on different worldviews.\textsuperscript{97} My view is that there is a need for concerted efforts for its promotion and youth involvement, including key pragmatic strategic and practical approaches applied which emphasize the mitigation and curtailment of sorcery and associated negative practices, as vehemently mentioned by all the THs interviewed. Some THs are not enthusiastic to share information regarding their TMK, partly due to suspicion that the knowledge will be ‘pirated’ for private profit, but also due to false THs who may claim knowledge of the medicines while giving customers wrong doses which can prove fatal. This resonates with the literature discussed earlier, which denotes that THs and doctors in China prefer keeping effective and original prescriptions as “family secrets” and only telling them to people they trust\textsuperscript{98}; in effect, a form of withholding valuable property rights on TMK, which I discuss in Chapter 5.

Respondents narrated how they believed that the youth, who migrate between these two knowledge systems, take action based on the predominant worldview. The healers expressed concerns about growing tensions between the youth and elders, that knowledge may be lost and undermined, and that biodiversity is threatened and diminishing. Ntuli (2002) argues that the increased migration of the youth to urban centres denies the younger generation traditional community support systems, which include education in survival skills, communication skills, safety, and conflict prevention. In my study I saw these learning processes as involving both familial and non-familial relationships, which has also been discussed by Newman (2008). Families are the obvious intergenerational

\textsuperscript{97} TMK is very much part of the present and part of a complex mix of therapeutic strategies that South Africans of all colours and classes might use (Thornton 2009).

\textsuperscript{98} www.chinaview.cn - accessed 2009-05-07
connections, and multigenerational learning interaction predominates in the study.

The study highlights gender and presents the important role played by women married away from their clans in the transmission of TMK. Older, and some younger, female THs are seen as re-emphasizing the values of the gift and TMK to local communities in relation to the attitudes towards its use management and its commodification, which I discuss further in the next empirical chapter. This study reaffirms the argument by Eyssartier et al. (2008) that women whose TMK learning continues during adulthood have played a role in transmitting not only their traditional knowledge but also certain values in relation to natural resources, generation after generation. Older female respondents discussed how they bring the TMK they learned at home while growing up to their marital place, while negotiating new ways of sustaining TM products through cultivation practices. The women’s cosmological knowledge and worldview on traditional medicine and ceremonials, which Carter (1996) argues has not been addressed specifically in research literature, while often undermined, is seen here as living and taught, passed on among older THs as well as from older to younger generations irrespective of gender. The gendered patterns of migration and labour markets which dictate a predominance of younger male migrants show in this study that mainly male THs predominate in the urban space and places.

In Voeks’ (2007) research on women in Brazil, especially older women predominantly represent the primary health care providers for the family and the community. In this study, however, both older and younger women as well as men are active THs in providing primary health care in the region of study. Female THs generally have specialized knowledge of TMK used during prenatal and postnatal delivery for the care of women and children, though the study shows a minority of male THs specializing in this.

Despite the above-mentioned legacy in the study area, most THs in the study could see new roles for THs and emphasized the promotion of TMK as a

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99 My empirical study provides examples of intergenerational learning between father and son, mother and daughter, mother and son, grandmother and grandson, grandfather and grandson, and grandfather and granddaughter, as well as intra-generational learning between sisters and in-laws.
continued important aspect in community health in response to rapid socio-spatial changes and dynamics. This resounds with Ntuli’s scholarship in Southern Africa, where Western physicians are increasingly working with indigenous science broadly and indigenous medicine more specifically (Ntuli 2002). Guided by the WHO-initiated promotion of TMK, which propounds its cultural legitimacy, scientific rationality and economic potential, in stark contrast to the colonial suppression of TMK100, I sense this promotion prevailing in cooperation with various actors in Tanzania and Kenya. Ongoing collaborative mechanisms between the formal medical/educational establishments with formal and informal TMK institutions suggest this, as discussed in the previous chapter.

Thus, the empirical findings reveal practical ways in which the TMK learning processes are characterized by learning systems lived by an apprentice, who learns and develops skills over a number of years. Prayers to deities and rituals, coupled with oral narratives, ‘learning by doing’ ‘being sent’, preservation and storage techniques, as well as dreams, are core components of the learning process.

100 See Sugushita (2009).
9. From rural gift to urban commodity - THs perceptions of the commercialization of TMK

9.1 Introduction

Thousands of cars have been waiting for days along the road to Loliondo, Arusha Region in Tanzania. Sick and healthy, poor and wealthy, including dignitaries such as members of parliament from Tanzania and neighbouring countries, are lining up to drink a cup of mugariga, a magic mix said to cure various diseases, including AIDS and diabetes. It is prepared and served by the retired pastor Mzee Msapila, who claims to be a messenger of God. It has been reported that hospitals in the area have been emptied and that pharmacies are losing business.

Unlike many other urban based THs, both genuine and crooks, his charges for services rendered are quite modest, obviously not pegged on the economic theory of demand and supply where the price of the commodity or service goes up whenever demand outstrips supply – his service charge is a mere Sh 500 [less than 0.5 USD], which he reportedly shares with the church and his assistants who spend much time in the bush, in search of the necessary raw materials (IPP media, 27 March, 2011).

The Loliondo phenomenon sets the scene for this chapter. It illustrates the demand for herbal medicine and that new actors, in this case a pastor, have entered a space traditionally occupied by THs. TMK and products are becoming commodified and commercialized, and the practice of traditional medicine is increasingly becoming an urban phenomenon. The purpose of this chapter is to examine how the processes of commodification of TMK and products are viewed by THs in the context of dynamic socio-spatial transformations such as urbanization and commercialization in Mwanza (Tanzania) and Nyanza (Kenya) in the Eastern Lake Victoria Region. The guiding questions are: Do TH view commercialization as undermining TMK or do they see it as an opportunity? How do THs navigate their profession in the light of socio-spatial transformation such as urbanization? Are the views about commercialization homogenous, or are there contesting views among TH?

What are the rural and urban linkages related to use, management, commercialization and commodification of TMK including gender implications of
those linkages, and what are the existing incentives for the youth to use this acquired knowledge base as a resource to sustain their livelihoods? Although fieldwork has been conducted in two countries, the aim is not to compare them but rather to look at the region as a whole and give examples from both the Kenyan and Tanzanian sides.101

TMK has often been regarded as authentic and homogenous, and empirical research with heterogeneity and changed practices has been limited. There is therefore a need to inject more empirical evidence into the discussion, as emphasized by Vermeylen (2008) in her study on the views on the commercialization of TMK by the San people in South Africa. Vermeylen states that the variety of ideas and perceptions about TMK encountered on the ground need exposure.

In rural Tanzania as well as rural Kenya, despite a process of deagrarianization, farming and livestock-keeping have defined, and continue defining, people’s occupational identity (Jonsson et al 2009). The urbanization process is mainly driven by the younger generation, with a majority of migrants in their 20s (Oucho et al 1993). With a population of 65% under 25 years of age, the mere dynamics of the population also contribute to the fact that many migrants are young (Van Dijk et al. 2001 and Helgesson 2006). However, in many communities the ‘place’ of youth in terms of voice and authority is not recognized (e.g. Helgesson 2006). One example of this was that it was difficult to get access to younger healers/apprentices who, due to their junior position, did not actively participate in the interviews or FGDs in this study. However, as will be shown in the empirical sections, it appears to be that a younger generation of male healers are driving the diversification of the TMK livelihood. TMK as a livelihood opportunity for youth in urban areas has been recognized by NGOs and researchers in the region, as the following quote illustrates:

Young people meet me. Their lack of employment means that they constantly ask me where they can go and train as TH. It pays more in the city! (Female researcher 50 yrs KEMRI, Kenya).

101 Some National differences between Kenya and Tanzania are discussed in some sections in chapters 5 to 10
9.2 Traditional medicinal knowledge – from gift to commodity

A common description of TMK among the THs interviewed is that it is a gift provided by a higher power, and the role of the traditional healer is to use this gift as a social service to help the community, without requesting direct remuneration. Mhame et al. (2010) note that traditional health care services are practised and embedded within the *Ubuntu* philosophy (an African ethical or humanist philosophy focusing on people’s allegiances and relations with each other), premised on Ntuli’s (2002:61) description of attempts by African societies to seek “interdependence, interrelationships and an interconnectedness of all phenomena”. The *Ubuntu* philosophy therefore requires that THs do not provide services for material gain, obliging them to provide health care services to their patients without demanding payment.  

The traditional healer therefore functions as a medium through which patients are able to obtain help from the medicinal plants. The THs are in contact with the spiritual world, from which they obtain guidance and support in diagnosing medicine through dreams:

Money is not the most important thing. This is what this medicine is for, to help people. You get a lot more than you give and you may even all of a sudden see someone who brings you something which you didn’t expect, like a blessing that comes to you. It’s as if helping will make you recognize the medicines since they come out in your dreams. They originate in dreams so that you will know them and what you can do with them, so that you don’t forget. But if you are somebody who is only after money, you will forget them (Female TBA 52 yrs Homabay, Kenya).

This female traditional birth attendant describes and re-emphasizes the complex web of exchange and obligation involved in the act of providing TMK. The TH profession and practice are embedded within a gift economy, whereby reciprocity and mutuality are paramount within a holistic worldview. THs are given gifts

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102 TMK is discussed within the empirical study as the ‘gift’ the THs hold as custodians and are obliged to share with community. This taboo imposes on the practitioners a strong code of ethics in the provision of health care services to which they should always abide. This places a huge responsibility on the individual TH to demonstrate a high sense of ‘professionalism’ and integrity in the discharge of his/her work. A TH who believes in *Ubuntu* strives to provide health care services according to the tenets of the taboo. See Mhame et al 2010.

103 A longer definition of how TMK is embedded in this worldview is discussed by Oguamanam 2006 and Mgbeoji 2006.
(ralam yath\textsuperscript{104}, gonyo\textsuperscript{105}, kipaji) as acts of honour and respect. The gifts are tokens of thanks for the provision of help to the individual or community, symbols of gratitude for the power which is perceived to have enabled them to deliver the service. In other words, the social context of the therapeutic process requires reciprocity and this payment contributes to the effectiveness of the treatment. This is described below:

For example there was someone I healed who gave us a house. It is this house we are inside. It was the Arab man Ali (\textit{shows the picture...describes the family in the picture}). The daughter wearing the dress [...] she was \textit{`mixed up’}. They brought her here from Oman. When she got completely well, they came back and he built us this house which we are living in and we moved in. There remained a lot of roofing and he and we then built an extra ward...yes, it was the year 90! (Male TH 42 yrs FGD Magu, Tanzania).

Most respondents argue that genuine THs also treat those who are unable to present gifts. They often say their job is their destiny, a destiny to serve the common good and heal people in need as opposed to making money; thus the term ‘help’, as illustrated in the quotes below, a term used by all male and female THs in the study to describe their profession. Most female THs were of the view that TMK knowledge should not be `paid for’, and some male THs shared this view. Note also that the healers make an assessment of who can afford to pay and who cannot, depending on the wealth of the individual patient or family:

Now those who don’t have anything or those who are unable, you look at the person. Some, you can see where he is coming from and you can reduce the fee for him. It depends on where he is coming from, on his circumstances, is he not a human being? Well, sometimes we treat them for free! So it depends on the patients’ ability, payments are negotiable (Male TH, 40 yrs Magu, Tanzania).

You must have a heart to help, even if a person does not have money. You must help (Female TH 50 yrs Homabay, Kenya).

I treat a mixture of local people and people from far away. Sometimes there are those who do not have money. Those I try to help like those who live here in the local areas [...] Who live in the neighbourhood in our village, they are from our village...I treat them free of charge [...] eh, that is very good! (Male TH 62 yrs FGD Mwalina Magu, Tanzania).

\textsuperscript{104} `token prayer’ (initial payment)
\textsuperscript{105} `to untie’ (installments in form of livestock, agricultural products)
Let me ask you on the side of the money how do your people pay you?

Yes my people pay me according to agreement. It follows how someone is, even sometimes even if you go into the car (a bus), is it also not so that, you, they will 'cut for you a lot' and me, they 'cut a little' because they see that I am small, small! ('Thin thin') while you are large and broad so you occupy...

Yes I 'open' the chair...laughter...

I have taken a larger chair, and you have taken a smaller chair, so that is how it is, although the maximum which you can pay sometimes is 1,000 KSh. (USD 15) (Male TH 55 yrs Gem, Kenya).

A gift to a traditional healer, in the form of traditional food products or livestock, is no longer regarded as sufficient. The exchange of services related to traditional medicinal products is experiencing dynamic changes, described here by a female traditional healer who makes a comparison between generations:

When I gave birth to my daughter, there was no money paid. The next morning when the person who had helped came, she was given a cow and a chicken.

Does it look the same now?

These days money has replaced it all. Money has taken over. If you are a traditional healer, it is with money people beat (negotiate). In the beginning they came with a chicken in their arms. Now, when cured and happy they give you 1,000 KSh (USD 15). That’s when one has given birth and you have thrown the placenta (birth without complications). If she refuses to give something...I don’t demand. If she doesn’t give me anything she will come next time, won’t she? You don’t demand, she should see it herself, how you helped her have a child, yes! (Female TBA 76 yrs Kanyamwa, Kenya).

Yes yes yes!, for instance me here, there was one mama who came here and said ‘me, I have a daughter of mine who has a good job’, we agreed that we would meet in Magu here. She told her mother to come, and said, ‘my daughter all that debt when she comes, she will come and give it all here’, and so I said there is no problem. I treated her until I bid farewell to the mama. She told me ‘I do not have transport fare to return home’, so I told her ‘tell me your costs, from here to Mwanza, Mwanza until another journey to home at yours...’ (emphasis of distance). I counted the money and gave it to her and I treated her you know as a bond. As a bond; me as a bond knowing she would bring the money, and fare I gave her, it was up to 30,000 TSh (USD 35) even for treatment... because to buy things you know for medicine and what...basi (so) she went. (Male TH 40 yrs FGD Magu, Kenya).
A TH may expect to get something in return for successful service, but does not demand that the patient give something. The receiver of the treatment should realize this and compensate for it next time she/he comes. As Mauss (1924) writes, a moral bond between the persons exchanging gifts is established. In other words, the gift economy is perceived to be based on the obligation to give something back in reciprocity (Zerda-Sarmiento et al, 2002):

So a long time ago you may say money but it ‘defeated’ the person so he could give you a goat or a chicken or a cow or other things, even food. The people who are treated have come here with many chickens... I do not like taking cattle and animals from people... because households are different, even recently when I went ‘behind’ Godera Forest to treat someone who is a drunkard, who they want to leave alcohol, when they removed a goat I told them I will not take the goat please just sell it, the money which God gives you, you will give me... because even if you pay me a lot of money it gets finished, these ‘things’ the way I get them is not in a very difficult way, some I dig myself but they are things which God created, so it is knowing them which enables me to help someone (Male TH 55 yrs Gem, Kenya).

The quote also illustrates that there has been a shift in compensation for treatment from gift to money - from a gift economy to a cash-based economy. TMK is increasingly becoming a commodity while the role of the traditional healer may be redefined with the commodification of TMK, as discussed by Swantz et al. (1996) and Bode 2006. Bode (2006) views it as the erosion of patient-traditional healer dynamics and the gift in the commoditization process in the context of Ayurvedic and Unani TMK. Although here the mode of payment has changed to cash, this should not be interpreted as a shift to a market economy. However, there are other changes in the practice of TMK which point in this direction, as will be illustrated in the following sections.

9.3 Urban patients and symbolic payments

The use of TMK is not only a rural practice driven by inadequate numbers of formal medical doctors and clinics. It is embedded in a wider belief system which has spatial, temporal and place-specific dimensions and is also used by urban patients. “THs are often itinerant merchants of fortune settling in urban communities and attending to the needs of countless clients with whom there is no ancestral affinity but only perhaps a shared worldview” (Oguamanam
2006: 129). As Chapter 7 shows, urban dwellers visit rural THs, while Mhame (2004) estimated that 2,000 of an estimated 75,000 traditional health practitioners in the whole of Tanzania are urban-based. In following quote the healer refers to urban patients who, after a first symbolic payment, pay in instalments according to the treatment needed:

Generally urban people who come give a symbolic ‘token prayer’ for the medicine, about 500 KSh (USD 7). ‘Gonyo’ (‘to untie the disease’), requires a second, third and fourth instalment, which can be 700 KSh, 1400 KSh, etc. When he gets well he may never be seen again! Chickens are used as payment, but not grains as before (Male TH 75 yrs FGD Kanyada, Kenya).

The patients truly cannot give you the payment there and then, no way! And you tell them 50,000 TSH (USD 30)? Eh! Never! Nowhere! You tell them, this disease you can start with 10,000 TSh (USD 6) or 15,000 TSh (USD 9), then you start to treat him, then when he heals [...] actually to tell you the truth we have a lot of words [...]. There are others who leave even when they have not healed [...] or another one gets well completely and you wake up in the morning and he is not there! (Male TH 45 yrs FGD Magu, Tanzania).

This quote also illustrates a problem related to an urban population, namely the lack of social control in urban areas. While it is difficult for someone in a rural area to escape responsibility, it can be difficult to trace a person in an urban area where the social control of the community is less pronounced and the aspect of anonymity also exists.107 As shown in the quote above, the traditional healer is not certain whether the patient will fulfil his commitment.

People with ‘kichaa’ and ‘kifafa’ (mental disorders) initially give us 50,000 TSh (USD 50). When they heal, they give 80,000. Other minor ailments, those we can look at and negotiate. We can look at the individual concerned, because this may not involve a lot of work or challenges. He can give 30,000 TSh. There are others who could give 20,000 or 10,000. Sometimes we can see that when he heals, he may give 30,000, or maybe he can give one cow, but at least he will have healed...! (Male TH 40 yrs Magu, Tanzania).

As seen in both the quotes, there are different prices for different ailments. However, the price can be negotiated and determined both by the healer and the patient. The traditional healer can make an estimation of the level of effort involved, and the economic situation of the patient. The patient may also decide the price according to his/her economic situation and according to the effectiveness of the treatment. As we have seen, a common mode of payment for

107 City life and urban lifestyles have been explored in e.g. Jourdan (1995) and Tranberg Hansen (2004).
treatment today is cash, but also livestock, linked to the societal agro-pastoralist orientation where livestock remains an important symbol. Therefore, even if a person resides in an urban area and has access to cash, he/she may choose to pay for the healing in the form of a cow, goat, sheep or chicken because of its symbolic value. It can be argued that paying for traditional healing or medicine with livestock can be a way to conserve the gift economy, i.e. compensate in the traditional, symbolic way. The alternative and new economic livelihoods and opportunities linked to urbanization and mobility are renegotiated alongside traditional livelihoods such as animal husbandry, depending on whether the beneficiary is within the urban or rural space.

A large proportion of traditional medicinal products sold in both rural and urban markets has what Cunningham (2008) defines as symbolic or psychosomatic value for luck in finding employment, guarding against jealousy, love charms and aphrodisiacs to keep a partner. Increased migration to urban centres to make a living has created a need to maintain one’s relationship with the partner left behind in the rural area, and a demand for finding new partners in the urban environment. The ease of relationship-building in the rural setting, where families know one another, risks being lost when individuals migrate to urban settings with their more heterogeneous society. Urbanization brings geographically separated groups into contact with each other in new social, economic and cultural settings. An example of traditional medicine being used as a charm to solve a troubled relationship is shown in the following quote:

They are increasingly from the urban areas, and they have other problems, not just diseases. And mamas come (laughter)... The mama wants him to stay at home. She wants him to ’sit down’. A man may be going this way and that way, and the economy in the house may be bad. [After treatment] he does not come home anymore at midnight; he now comes home early in the evening. Because the men are giving them trouble, they want them to stay at home...! (Laughter). Do you have this in Kenya? [Asking the researcher, who is of Kenyan origin]. So they charm the man. ‘I need to charm him’, so if charmed, he can bring in money. Therefore, one ‘makes something’ (prepares medicine). After this, they can talk together about their children; he can sit together with her, yes! He can do anything you want and he listens to you (Male TH 60 yrs FGD Mwalina Magu, Tanzania).

As seen in the quote, urbanization has brought with it an increase in practices of TMK which address social problems rather than illnesses. Rural-urban migrants
are met with the need to adapt to new socio-economic and socio-cultural environments (Nasheim et al. 2006) which challenge aspects of their lives including beliefs, values, health practices and knowledge. Integration into the market economy in the urban space also brings about changes in social organization, health and well-being. THs play an extremely important role in health care, and treat chronic and infectious illnesses. In addition, they may also be called upon to treat social and ‘psychological’ problems as well as problems not commonly perceived as ‘illnesses’ by people outside Africa, such as difficulty finding a lover, difficulty conceiving a child, or lack of success in business affairs. Research has found that women are especially vulnerable to ailments such as STDs and HIV/AIDS, as well as other social issues and challenges linked to rapid socio-spatial transformations. Being the primary caretakers, and holding significant responsibility for the health and well-being of their families, women often constitute the majority of THs’ clients (Homsy et al 1996). One example of this is shown above. Premised on a holistic approach to health, TH treat body, mind and spirit as an integrated system, often in the communal sense of the ‘social body”. The traditional healer adjusts interpretations; in the village the cause of illness is interpreted as a manifestation of ruptures in social relations between neighbours and kin, whereas in the city the illness is interpreted in relation to co-workers and neighbours (Swantz 1996).

The process of neoliberal globalization is translated into national public service economies in conflict with an increasing privatization and neoliberalization of public services including health. In recent years the new market economy in this region has seen an increasing privatization of health care with varying degrees of commercialization and commodification of communal resources (Gibson 2004), including TM plants, which has further compounded the problem of accessibility to mainstream health care. One of the impacts of neoliberal policies in Tanzania was that health services became expensive for the majority (Mshana 2002).

A large proportion of the urban population in Sub-Saharan Africa consult THs due to the widely held belief that good health, disease, success or misfortune are not chance occurrences but are rather due to the actions of individuals or ancestral spirits (Cunningham 1997 and Wondwossen 2005). The abundant
availability of traditional medicinal products in the markets of urban places is an indication that TMK is popular among urban residents. In her wide-ranging study on the history of medical studies in Tanzania, Swantz (1991) found much evidence of the role the THs play today, even in close proximity to the modern urban hospitals and professional practitioners of bio-medicine. As documented by Langwick (2008), in Tanzania there is often a close link between bio-medicine and traditional medicine at the hospitals, mediated by nurses as well as patients. There are also potential transnational links related to traditional medicine. Mander (1999) argues that recent urbanized populations and nationals living overseas have generated a strong demand for TMK and products, which are viewed as one of their few remaining links to a traditional village way of life.

9.4 “You have to pay a fee and it is far”

Some plants required for certain medical preparations are no longer abundant or even available locally. Gathering these plants requires travelling long distances, and harvesting plants may involve the payment of fees to the forestry authorities or the landowner. It can be argued that this contributes to THs today requesting monetary payments from beneficiaries:

> These days we are suffering to get the medicines because you have to go far! Now you need to go further, to Kahama is far, Geita, even up to Tabora! You have to give someone a fee to go to the forest. These days we get them while going through problems. You can get there, negotiate with them and pay. Then you dig what the mzizi (roots) give you. If you go to the forest you can get them, but we get them with a lot of difficulty. You have to pay the fee and it’s far. You take a paper from the licensing department and when you get there you negotiate with them and take the medicines and come back. Yes, you have to pay for the licence, and then meet the forest men, and pay some money to the special officer (Male TH, 55 yrs Magu, Tanzania).

> Cutting the forest has caused their scarcity. I go to the bush and harvest the ones I saw in my dreams. I travel to the places where they are. Taxi transport charges are high. I get them through difficulties when I go to places far away. It’s expensive and you have to hire a taxi. If I go to someone’s bush, I have to pay the owner of the bush. I have cultivated some on my land, for instance okita, ohuya, ndawa, which are rare, even the seeds (Female TBA 52 yrs Homabay, Kenya).
I have not started cultivating them but mainly your brother\textsuperscript{108} J brought me from Wiga, and some I got from home. Some I buy, some I collect. Those that are not in my area, I buy them (Male TH 62 yrs Homabay, Kenya).

One of the reasons the plants have to be gathered from far away is due to deforestation, as mentioned in one of the quotes above. Wild medicinal plants are becoming scarce due to changes in land use and state policies, overharvesting and deforestation, and the subsequent reduction of biodiversity. It can be noted from the quotes that the issue of scarcity of medicinal plants is a problem on the Tanzanian as well as the Kenyan side. A combination of purchasing TM products and harvesting them seems to be the evolving strategy for some of the respondents. As seen in Mander’s (1997) scholarship on South Africa\textsuperscript{109}, some THs buy raw or semi-processed products from harvesters and traders, and use them to process complex prescribed mixtures to treat their patients, while some cultivate small quantities of raw products for their own use; although in the urban space the bulk of the trade in medicinal plant products takes place at the informal street markets. Exclusive harvesting, which defines land use around urban areas (Nygård 2000), is slowly being replaced by purchasing the TMK products for further sale. As seen in this study, over the years the types and modes of ‘payment’ to the THs for their services have been changing, especially in urban settings where the THs increasingly demand monetary payments.

The contemporary land policy has its origins in previous colonial state economies that established export-oriented crop production, which set the stage for land commoditization and the associated struggles over its control and uses (Bernstein 2000), whether private property or under legal state colonial codes. The prevailing policies have specific impacts on the direct or indirect access through harvesting by THs and beneficiaries of traditional medicinal products. As indicated earlier, since 2001 the land policy in Tanzania has been changed eight times, while today approximately 2% of its 42 million inhabitants have traditional ownership titles. Traditional medicinal products are becoming increasingly difficult to obtain due to environmental degradation, deforestation and strict harvesting regulations within the prevailing land tenure system.

\textsuperscript{108}refers to a cousin of the field assistant

\textsuperscript{109}Mander’s scholarship was conducted in the Kwa Zulu Natal Province of South Africa, which has the largest urban market space for traditional medicinal products in Southern Africa.
When we get there it is important to find the natives of the place and agree with the village elders on the use of their land! (Male TH 55 yrs FGD Mondo, Tanzania).

There are some medicines that are getting lost - some trees are getting lost, because of burning of trees, there are side effects, not only the result of TH’ activities; there are many ways which are causing this problem, with fire burning anyhow, not only THs...there are some trees that when burned are unable to ‘stick’ again, there are also trees you cut down then the trees do not grow properly again...like the charcoal burners, they sometimes destroy the seeds. Then the trees are unable to germinate again. That is why you find that there are many trees which you do not find here anymore. Then you may find them where the rain falls a little bit and the trees then may grow in the forest where there is more water and rainfall. There are trees that, if absent, the general vegetation is affected and also disappears. There are other aina\(^{110}\) which grow only in the vicinity of these trees so if the trees are not there then they also do not see them ... they disappear! (Male TH 60 yrs FGD Mondo, Tanzania).

Some of the THs indicate that they have set aside land for the purposes of cultivating TM plants, which has its drawbacks. This is expressed in the excerpts below, where we also see the role of women married away from their clans and bringing TM plants to their marriage homes:

We have a shamba\(^{111}\) but we have not arranged the shamba we have bought...but we grow maize... you know how it is; it is not easy... but we now grow maize, mpunga-rice, sorghum, but we have a plan with mzee\(^{112}\) that we go and buy a shamba with two acres and plant medicinal plants that we can get from Bukoba and we try to cultivate slowly slowly... and see if it is able to grow, then it will be better for us... We have that plan. However it’s also an issue that if I plant now then it will take me how long... how many years before I start to harvest and you... you want it now...! (Female TH 36 yrs FGD Magu, Tanzania).

When he goes to the forest does he have to have a licence? Does he pay? Or does he have a licence already...?
Yes he has to pay and to meet the forest men, pay something to the special forest officer.; it is becoming more of a problem to get the medicines.
Do you have plans for a shamba? Your own farm to plant the trees?

It is difficult even if you have a shamba. To plant... there are many patients even if you plant by the time the tree grows and reaches where... the tree takes long to grow...it is difficult...You are treating people...Perhaps by waiting then it has grown in five years, the patient is dead by the time the tree has grown (Male TH 55 yrs FGD Magu, Tanzania).

\(^{110}\) Aina literally means types, species in this context.

\(^{111}\) Swahili term for a parcel of land used for agricultural purposes. Also used by urban residents to describe their rural home.

\(^{112}\) Term used for the husband of the home or an old man, and can be used as an endearing term for a young boy.
Increasing populations coupled with increased scarcity of land have necessitated a decrease in the wild harvesting of traditional medicinal products and an increased awareness among the THs of the need to start cultivating TM products in their homestead. A twin process of land shortage and the reduced availability of medicinal plants has prompted THs to experiment with alternative activities like establishing a *shamba* to cultivate some medicinal plants. From earlier discussions it can be argued that THs may prefer purchasing the products from traders and harvesters rather than cultivating them themselves, as some argue that the trees would take a long time to grow.

The Ujamaa land policy’s specific impacts on the direct or indirect access to land resources are discussed by Swantz et al. (1996):

> The commoditization of village land was one of the many unintended consequences of Villagization resulting from the subsequent disruption of the land tenure system. At the time of Villagization, the selling of land was rare. With the drought of 1974, people from the city began to obtain land from villagers for cultivation. According to Tanzania’s property laws, the produce and ‘development’ of land could be given monetary value. While the land itself could not be commoditized, after the mid 1970’s the purchase of land soon became common practice. Regardless of whether the owner of the land had an official title to the land an unused piece of land could change hands several times and in the end have several claimants simultaneously (...) Some of the initial problems in defining land holding rights were clarified when the National Agricultural Policy (1983) was made public, though in practice there was still much ambiguity in many parts of the country...’ (ibid: 148).

Studies on land degradation in relation to traditional medicinal products and food security in the Eastern Lake Victoria Region have been undertaken by, for example, Ong’an’ga (2003). In Tanzania, one of the consequences of the Ujamaa villagization programme\(^{113}\) was that traditional methods of use and management of TMK for sustainable land use were discarded (Kiunsi 1994). A more recent process is the formalization of land process, in Tanzania under the Property and Business Formalization programme MKURABITA inspired by Hernando de Soto (Sundet 2008). The collection of firewood contributes to deforestation, and the control of logging on a large commercial scale for export remains a challenge. The exploitation of medicinal plants is expanding due to the development of

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\(^{113}\) Policy aimed at the resettlement and concentration of communities geographically around social services such as water, health and education. The *Ujamaa* villagization programme involved the largest number of people in the history of African resettlements, relocating between five and nine million rural Tanzanians (see e.g. Kibula 1997).
medicinal plant industries, regionally and internationally, discussed in the section *Traditional medicine on the market – a contested space*.

### 9.5 Livelihood diversification among the younger generation of healers

The younger THs differ in their approach to the commercialization of TMK. Younger TH request monetary remuneration, emphasize that it is a profession they have learnt, and tend to diversify their livelihood related to TMK so that they are THs as well as traders of traditional medicinal products. Apart from being stratified by generation, attitudes towards the profession seem to vary according to gender, with older female healers emphasizing that traditional healing is a gift from above and that you cannot demand payment, preferring to adhere to the socio-cultural context of a gift economy. While research from various regions shows gender awareness as central in understanding forms of use and management of natural resources, Eyssartier et al. (2008) indicate that women play a role in transmitting not only their traditional knowledge but also certain values in relation to natural resources, generation after generation. I view the female THs who maintain attitudes towards the healing values of TMK as linked to the gift:

> I just provide help through medicine, I feel sorry for them. If you see your fellow human being who is very sick, you must pity and help him, especially if his time for ‘dying has not come’. If you don’t help and let him die, you will have done a bad thing because God gave you this medicine to help and treat people (Female TH 80 yrs Karachuonyo, Kenya).

> At the market I sell medicines. When a patient comes for diagnosis, I listen and then diagnose. I ask the patient to give me something in return. Reward is based on understanding and it can be payment by chickens or money. I have not taken a goat; I sell it because I don’t want something big. We prefer money, but many give goats and small chickens. Payments is a problem, people usually don’t pay well. What God gives, you will in turn give (Male TH 53 yrs Gem, Kenya).

> When you come I just tell you the amount of money which we have agreed on. What I tell you is what you give me. I’m doing two jobs when I’m selling at the market. I treat and I sell. You will buy what you need and you are the one who knows how you are going to use it and we don’t discuss the price. If you come saying you are sick and ask ‘what can I do?’ then I just listen and catch it and identify the medicine in my head. Then we agree. If it’s something we can do there and then, we do it (TH, male 53 yrs Gem, Kenya).
While the first quote is by an 80 year old female healer, the other two were by a male traditional healer. Although he is over 50 years old, he is still considered a relatively ‘young’ healer, as the profession takes years to acquire and master. The quotes can also be seen in the light of socio-spatial transformation, whereby people are moving to urban areas and adopting urban ways of living. This healer is an example of a new generation of urban-based THs, often male (most urban-based THs were male), who sell medicine at the market as well as treating patients. TMK is increasingly becoming an urban profession, and especially the younger healers tend to diversify their livelihood activities by combining healing with trading at the market. As also can be seen in the quote, he stresses that he sets the price and that it is not negotiable. Cunningham (1997) discusses the migration of THs from rural to urban centres in Africa as a strategy to improve their livelihoods. This is also well documented in studies conducted in Dar es Salaam, Tanzania, by Swantz (1991) and in Nairobi, Kenya, by Good & Kimani (1980), and is in agreement with research on livelihood diversification among the younger generation in general (e.g. Helgesson 2006). Commercialization and urbanization with the related migration trends are seen to be a direct contributory factor to transforming the role of THs and to dynamics of traditional medicinal products in both rural and urban contexts. As shown in the quote below, some THs compare their profession to that of someone who has studied medicine at university. The male traditional healer in the quote below emphasizes his professional identity as a healer, and that his knowledge should be properly compensated by urban patients:

I studied this medicine just like someone who goes to school, reaches university and succeeds. Now I know this thing inside and out, so these days during my conversations with patients, since they own cars, I just tell them to put down the payment and they let me treat them (Male TH 65 yrs Gem, Kenya).

When young people see the income potential of TMK, such as the marketing of traditional medicinal products, they show enthusiasm.

This was expressed by a traditional healer who himself is based in an urban area where he sells TMK services and products at several marketplaces. He also brings products to rural areas. The quote illustrates that the new generation of healers
move between different places. Apart from this mobility, the quote also shows the rural-urban dynamics of traditional medicine:

The youth are interested when they see me, that I have an income. I sell at the market, and on Wednesdays I have to go to Homabay because I take [medicine] to the people of Homabay, the ones they don’t have (Male TH 56 yrs FGD Homabay, Kenya).

THs often pass on the profession within the family. The quote below is an example of livelihood diversification within the TMK livelihood, whereby the older and younger generations have divided the labour between them. The division of labour also has a rural-urban divide. While the father deals with the plants in the rural area, the son sells the products at the urban marketplace:

If you go to Kibuye market, they [the youth] are the ones with stands selling these things. When we went to Mwanza, they are the ones who are selling at the market. You see, the father is the one who plants and his son is the one who sells at the market. They eat properly at home..., so now that is why NGOs have entered..., so that we should not lose these things (Female TH 58 yrs Suba, Kenya).

The quote also illustrates that non-governmental organizations (NGOs) are interested in traditional medicine from the perspective of being a livelihood opportunity of youth. NGOs working within communities are increasingly involved with health-related issues that link TMK and products with primary health care, such as in health care related to HIV/AIDS. Finally, the quote shows the cross-border interaction of traditional medicine in the region. The healer quoted is based in Kenya, but her observation is from the city of Mwanza in Tanzania.

9.6 Traditional medicine on the market – a contested space

THs are no longer the only harvesters of medicinal plants. Traders supply both local (mainly urban) and international markets. The growing urban market economy for TM products in this part of the African region is also discussed by Wondwossen (2005) and Jeruto et al. (2008). Commercial gatherers of medicinal plant material, whether for national or international trade, are poor and their main aim is not resource management but rather earning money, as highlighted
by Maundu et al. (2004). New opportunities are emerging in urban as well as rural areas, a diversification of livelihood strategies including marketing TM products and TMK, which may create a conflict of interest between THs, harvesters and traders of the products while helping them deal with the socio-economic challenges of contemporary urban life. Urbanization and migration processes have meant an increasing focus on the commercialization of TMK and TM products. This is a cause of overharvesting and the subsequent reduction in biodiversity. It is also a threat to a profession mainly based on social integrity, and is what Bode (2006) describes as an erosion of patient-traditional healer dynamics in the commoditization process. The role of the THs may be redefined with commodification, as shown in other research by Swantz et al. (1996). Traditional medicine is being sold on the market like any other commodity, and THs argue that the government has facilitated this process:

The government has opened it to anyone at the market. People at the market are openly announcing the use and treatment of these medicines: ‘If you take this medicine and mix it with this one, it helps to cure this sort of disease’, they announce at one market after the other (Female TH 49 yrs FGD Suba, Kenya).

The Tanzanian and Kenyan Governments have increasingly developed policy and advocacy frameworks, as discussed in Chapter 6, towards work with traditional medicinal products, drawing from and in collaboration with continent-wide and international governance structures. These policy approaches involve NGOs and THs at regional, national and local levels in both countries. An example of a forum where such actors congregate in both countries takes place on 31 August, the African Traditional Medicine Day, as part of a continent-wide initiative enacted by the African Union.

There are a number of joint commercial initiatives, for example between the Ministry of Health in Tanzania and the World Health Organization (WHO), to cultivate and extract the traditional medicinal plant *Artemisia annua* which grows in the Eastern Lake Victoria Region. The aim is to produce anti-malaria medicine, and the Tanzanian Government received support in developing the process technology for its local production and commercial production (WHO 2003). The production and commercialization of products based on TMK
generate considerable value, but the profits are rarely shared with the people who discovered them (Battiste & Henderson 2000 and Daes 1993) (as also discussed by THs in Section 7.3). Another example of a traditional medicinal plant which has come to be an important commercial product is *Prunus africana*, a fast growing species growing in both Kenya and Tanzania. The bark is highly valued for its medicinal properties, and it is exported to Europe for drug production (Marshall & Jenkins 1994; Walter & Rakotonirina 1995). Leakey et al. (1996) argue that the commercialization of traditional medicinal products is not only necessary but also potentially harmful: necessary to improve income and livelihoods, and harmful if the expansion reaches levels that necessitate outside capital investments to develop large-scale monoculture plantations for export markets.

Some respondents were interviewed on their views regarding the cultivation and commercialization of TMK. In Bunda in Tanzania I met a TH who is urban-based and involved in the cultivation of Artemisia and Moringa plants, both medicinal, which have a higher demand on the market than wild harvesting can supply. In Karachuonyo in Nyanza, one older TH had a garden where she planted TM from different regions in Kenya where she had worked in her younger days. She took us on a plant walk, where she explained the uses and management of most of the domesticated TM plants she had planted. The respondents were positive to increased cultivation. The younger TH in Bunda has this as a livelihood, while the older female TH informed us that she gives the TM products to those who request her help.

Some respondents emphasized that they are not enthusiastic about sharing information regarding their trade, due to suspicion that their products will be pirated or their ideas stolen, or misused, by either institutions or other actors, as the following quote shows:

> Conmen are also there at KEMRI. If they discover that you can treat, then you will never use that medicine. If you go to KEMRI then they want to employ you and share money with you, then people come and ask questions and get

114 A plant walk entails walking through a cross-section of plant varieties with medicinal value while receiving explanations of their use and effectiveness and TMK in general surrounding the available plants.
They take our ideas and never come back! (Male TH 59 yrs FGD Homabay, Kenya).

Teaching someone knowledge as it was taught to me, I still find that difficult in one way, there was someone with a good idea and they took him and gave him a job. Then it happened that he was sent away from the work. Then you know those people have remained with all his ideas. And then the customers who you used to get, they take (Male TH 60 yrs Kanyada, Kenya).

Many herbalists, they think they should also have the medicines I have, so they take the medicines anyhow, and at times they can give the wrong medicines like overdose, which can injure people (Male TH 63 yrs Homabay, Kenya)

The above citations touch on property rights with regard to the medicinal plant knowledge the THs hold. Due to the increasing commodification of TMK, healers are increasingly aware that their knowledge can be commodified and commercialized for the benefit of other individuals and institutions. They are therefore cautious in sharing their specific knowledge on TMK and their therapeutic systems with outsiders. The issue of IPR and the access to and use of TMK, coupled with the commodification and economics of TMK, emerges as truly complex (Mashelkar 2002) within a highly contested arena. The growing awareness by the THs of TMK ‘ownership’ and as holders of collective knowledge, linked with the services they render within the collective and their appropriation by formal and informal players, is challenged. The current IPR’s conceptual conflict with TMK, discussed by Kamau et al. (2009) and Mgbeoji (2006) is displayed, whereby unequal power and monetary benefits are seen as THs contest the benefits to the formal organizations engaging and requesting their services. A minimal fraction is ploughed back to knowledge holders from the formal organizations (Mashelkar 2002), while communities contributing to this knowledge seldom receive compensation (Brush and Stabinsky 1996). As a TH discusses in Chapter 7:

They take our ideas and never come back! They take the knowledge which we have and give them, they go and use it but no one comes back (Male TH 59 yrs FGD Homabay, Kenya).

The THs, increasingly aware of the monetary benefits of their knowledge, query the non-monetary returns they receive when some formal and informal partners engage their services and TMK. The appropriation of elements of their collective
knowledge of TMK is seen as being converted into proprietary knowledge for the commercial profit of a few:

If they discover that you can treat, then you will never use that medicine. You know those people have remained with all his ideas. And then the customers you used to get, they take (Male TH 60 yrs Kanyada, Kenya).

Globalization processes of capitalism marginalize the role of indigenous populations (Gibson-Graham 2006), with perceptions of these populations as a resource subject for the benefit of major economic actors in the globalized project. In this case, the view is that the THs are seen solely through their TMK resources subject to the use and benefit of external actors. The formal organizations in the study are viewed by the THs as economic actors in the national context. I further link this to globalization processes in which contemporary market dynamics increasingly meet and contest some evolving legacies of gift economies embodied in practices of TMK. I argue that globalization processes within IPR regimes can be emerging in the empirical area, through THs’ contacts with formal organizations claiming propriety rights and marketing products of vernacular knowledge on traditional indigenous practices (Zerda Sarmiento et al. 2002) such as TMK.

At the practical level, the THs have difficulty protecting and developing their own intellectual property rights through the contemporary policy climate, due to unequal power relations and the high costs of litigation, as THs discuss in Chapter 7:

5,000 KSh (USD 65) is required for the test for medicines [...]..How will we be able to pay when each patient pays 50 KSh (USD 0.65)? Our thing is not going forward! (Male TH 56 yrs FGD Homabay, Kenya).

A discussion on sorcery arises in the empirical data, particularly within the context of ethics, integrity and socio-cultural and socio-economic problems. In all the interviews, this phenomenon was mentioned and criticized by the THs, as discussed in the previous chapter:

The doctor from here, the health officer and so on, they came here while I was doing my work and said for instance ‘oh, she has been bewitched by so and
so...’. This creates enmity! Since I started this work I have never bewitched anybody, my job is to treat people. My work since the beginning is to see the illness and to treat the patients (Male TH 55 yrs FGD Magu, Tanzania).

Mesaki’s scholarship argues that there has been a rise in witchcraft incidence in Tanzania, epitomized by the phenomenon of killing alleged witches and albinos for “get-rich-quick concoctions” (Guardian, 2008; Duff, 2005 In Mesaki 2009). Despite a socio-spatial context of widespread access to basic education and strong legal penalties, as well as intense opposition by Christian and Islamic religious authorities, witchcraft remains an embedded part of Tanzanian popular culture (Mesaki 2009).

The role of sorcery has been highlighted in an era when the commercialization of this resource base is on the increase. This can be illustrated by the problem of albinism in Tanzania, which led to a government decree that all THs within the union had their licences revoked and had to reapply for them. This was a measure to curtail the increase in sorcery practices as a result of increasing commercialization, urbanization and migration. The extract below from a Tanzanian daily illustrates the problem:

People with albinism have appealed to the government to conduct continuous sensitization programmes to enable the society to realize the needs of albinos. This follows an outcry from people with albinism that they lived in perpetual fear for their lives due to continuing witchcraft beliefs. The Chairman of the Kagera Albinos Society (KAS) Mr Burchard Mpaka made the appeal in Bukoba Municipality on Friday. ‘People have not fully accepted that albinos are normal people. We were being stigmatized by the society due to our skin pigment. The government has to educate the people that albinos are normal people and were entitled to all social benefits he said. Mr Mpaka noted that most albinos lived in fear of being bewitched by witchcraft, a total of 17 Albinos were killed in Kagera region between 2007 to last year. Albinos lack pigment in their skin, eyes and hair. There are around 170,000 albinos living in Tanzania the highest rate of albinism in the world.1 in 3000 are affected compared to 1 in 20000 in Europe and America (Franckvogel: 2012)

At least 59 albinos have been killed since 2007 in Tanzania and their body parts sold for use in witchcraft especially in the north-western regions of Mwanza, Shinyanga which are both gold mining regions where superstition is rife. Similar killings were also reported in Kagera and Mara regions. Witchdoctors tell their clients that the body parts will bring them luck in love, life and business... (Franckvogel: 2012)
This phenomenon resonates with the earlier discussion that TMK use is experiencing a transformation due to changing socio-spatial processes. The commercialization of TMK is increasingly being experienced, due to migration as well as changing lifestyles and needs of individuals in line with changing living conditions. TMK can also be used for negative practices, as discussed above.

The citation above shows that THs are increasingly aware of commodification, commercialization, and IPR and ABS issues surrounding TMK. It implies awareness in relation to the increased benefits of commodified and commercialized medicinal plant knowledge (which they hold) for other individuals and institutions\textsuperscript{115}. THs may become even more cautious (as discussed earlier) in sharing their specific knowledge on TMK or their therapeutic systems to outsiders, including formal organizations. My argument is that this caution by THs in disclosing knowledge on TMK to outsiders may be further reinforced as a consequence of introduced polity on licensing requirements. Though documented evidence suggests that THs still practised their profession in some urban spaces irrespective of the immediate ban prior to official licensing, revoked licensing and the mandatory re-licensing requirement of THs in Mwanza may pose a challenge to the emerging collaborative mechanisms seen in this empirical study between the informal TH profession and formal sectors. However, legitimate THs who provide primary health care to communities (in concert with some of the formal health organizations in the study), may challenge formal partners in distinguishing legitimate and genuine TMK holders and practitioners from so-called ‘quacks’ and individuals engaged in sorcery.

The contested encounter between the contemporary intellectual property regime and the TH profession, which Oguamanam (2006) and Swantz (1996) discuss, meets a parallel in this study. The IPR’s unsuitability to TMK - which thrives in an alternative socio-cultural context to a market economy paradigm (where IPR thrives) - presents a contested arena and space, within which IPR governance structures for TMK are evolving in Kenya and Tanzania.

\textsuperscript{115} This is within an environment where herbal medicines in both countries are currently not regulated and there are no restrictions on their sale (WHO 2005).
A further question concerns how these governance structures provide an entry point and space (see Section 6.7) to safeguard the collective property of TMK, recognizing THs as knowledge holders, in an attempt to obtain equitable ABS. The negative aspects of TMK, such as sorcery (exemplified in the albino phenomenon in this study), could provide an example whereby mitigation attempts to curtail a societal socio-cultural, cosmo-vision and reality, which would require concerted efforts for informal regimes to act in concert with formal ones. Irrespective of the approaches chosen to curtail this vice, the regional dimensions of this problem are important, as seen in this study. This could further augment and expand the already on going collaboration between the informal actors and organizations in the study working with TMK.

9.7 Discussion and conclusions

As we have seen in the empirical material, although TMK has increasingly become monetized and commercialized, the shift from gift to cash does not necessarily mean there has been a shift to a market economy in the study area. However, the transition from gift to market economy is seen in the context of those who sell traditional medicine at the marketplace for a profit, and the extraction of medicinal plants for the pharmaceutical interests of domestic and international markets. While the gift economy is perceived to be based on reciprocity and mutuality, the market economy is based on profit accumulation and wealth maximization. TMK, with its belief in a non-material culture based on a particular cosmological view (the gift), is increasingly evolving as an emerging tested force in a changing ideological climate. The views of Mauss (1924), Polanyi (2009) and Swantz et al. (1996) on the gift economy, with its characteristic reciprocity and mutuality dimensions that still define and are applicable to contemporary societies, are undergoing changes, as seen in this study. They transform as they become increasingly interdependent on an evolving monetary economy. The formal organizational policies discussed in Chapter 6, which characterize a macro-policy climate linked to a monetary economy as described by Elson (1994), are regarded as ignoring the non-monetary economy that defines the gift economy the THs describe.
In recent decades the Eastern Lake Victoria Region has experienced marked social transformations, particularly due to migration and urbanization. The Luo and Sukuma communities historically and traditionally lived a mobile lifestyle, a ‘culture of travel’, migrating from place to place with large herds of cattle. What we see now is a different kind of mobility, namely to the urban areas in search for a livelihood. As has been shown in the study, it is particularly a younger generation of healers who seem to be spearheading the income diversification within TMK, i.e. treating and healing as well as trading. TMK as an attractive livelihood in urban areas can be seen within the context of deagrarianization, with opportunities not only for the traditional healer profession and trade of the products at the urban markets as well as in rural areas, but also for providing income from the products in the rural areas. It can be noted here that the Sukuma’s and Luo’s ethno-medical tradition may play a particularly important part in protecting health because, as seen in earlier discussions, effective commercial medicines are expensive and difficult for the local populace to procure.

As discussed earlier, there is a reinforced outmigration and increased mobility of the youth from Nyanza and Mwanza to seek alternative economic livelihoods (Francis 1995), such as the TH profession in other regions and in the urban centres outside the region. This can be partly attributed to the severely affected ecology of Lake Victoria in recent decades and the effects of this on youth’s livelihood opportunities. For instance, the fishing community livelihoods are influenced by national governing structures, which in turn are affected by international organizations and global structures. The increased exportation of fish commodities from the Eastern Lake Victoria Region, signifying the reinforced alterations of export commodities (mining in Mwanza and an export-oriented fishing industry in Nyanza and Mwanza), has had consequences on the rural and urban economies in the study area. This is in combination with the deagrarianization processes and the related decline in prices for agricultural produce. As the Sukuma and Luo communities increasingly interact with the market economy through the sale of evolving commodities and wage labour, the monetary economy increasingly gives rise to processes that undermine the local availability of TM plants (Wollenburg 1998). This is seen in the light of less value
placed on the gift economy of traditional plant medicinal knowledge, except for its commoditized and commercial value, even though this provides for a diversification of livelihoods. Gender dimensions show that the interviewed female THs re-emphasize values attached to the gift in a climate of increased commoditization and commercialization of TMK. In the citations they emphasize “God’s gift” “must have a heart to help”, “money […] not the most important thing”, “must have sympathy and help him”, which shows a certain view concerning the value of their cosmological knowledge of TMK. Earlier research shows that women and men have a differential division of knowledge with regard to TMK, and that older women represent the primary health care providers for family and community in many regions of the developing world (Voeks 2007); the older and younger female TH respondents in this study seem to have conservative attitudes toward commodification and a cosmological view on TMK that may be formally or informally marginalized as it meets neoliberal processes engaging an alternative paradigm than the gift economy.

The older TH who is also married away from her clan (in the Luo context) allows for learning processes of TMK to the region she is married into, in the form of cultivating TM plants she has brought over the years. This is also the case in Tanzania, where a female TH takes plants from her region of origin to plant in the shamba they have bought.

I argue that the role of sorcery, heightened in an era of the commercialization of TMK, can be linked to and partly assessed through some of the effects of colonial and post-colonial administrative strategies, for instance the reorganization of the traditional political and administrative apparatus of the societies in this study through associated land policies including chiefdom systems, whose governing structure included TMK. Their governing role, whereby decision-making processes entailed responsibilities towards TMK in the societies, including their ability to resolve conflicts (Brandstrom 1990), effectively had control mechanisms for sorcery and witchcraft. These structures have undergone alterations. My view is that a decreased ability for Sukuma and Luo traditional societal structures to control and curtail a prevailing unpleasant societal reality in everyday life – witchcraft – occurred. This is in a space where increased
migration, urbanization and the commercialization of TMK occurs. The transnational/regional nature of TMK and sorcery as defined in this study would require pragmatic formal and informal governance and advocacy approaches.

The changing role and trends of governance, administration and legal dimensions of the state, in parallel with increased agency and actors, as shown in the empirical study, are emerging as active players against sorcery and negative TMK practices as they gain space and place in this arena.

The influence of socio-spatial transformations on TMK has gendered and generational implications. The older generation of THs, females in particular, seem to be more reluctant to embrace the commodification and commercialization of TMK. The practice of TMK has changed over time and space, presenting new challenges as well as opportunities. While the increased livelihood opportunity in urban areas is perceived as positive, it is also seen as a threat that anyone today can sell and market TMK and products, such as the retired pastor in Loliondo, as the introductory quote illustrated. Odora Hoppers’ (2002) concern that traditional knowledge is being eroded is therefore a challenge in the study area, combined with challenges of deforestation and the formalization of landownership with the acquisition of land by multinational corporations, which has made the access to medicinal plants difficult. The commercial interests, where medicinal plants have become commodities on the domestic as well as international markets, pose a threat. One of the greatest challenges for pharmaceutical companies and markets is to recognize the cultural values of the commodity and to find ways to use and compensate for these values according to how TMK is practised, used and transferred.

The TH profession is seen as entering a contested IPR/ABS arena at a time when increasing socio-spatial transformations are modifying its role from that of a gift to an owned commodity.
10 Concluding discussion

Discussions with Dani, who had experience living and working with traditional medicinal knowledge during the pre-colonial, post-colonial and contemporary periods in Kenya, answered some of my initial questions about traditional medicinal knowledge and aspects of traditional healing as a practice. Much has changed since the period when she was called to be an apprentice, learning TMK and establishing her work within the community. I had perceived that little would have changed with regard to TH, particularly within the rural setting where she predominantly practised, even though she helped beneficiaries from the local to the urban space, and from distant places. This turned out to be different, in fact the opposite, as this thesis shows another picture. The social processes she mentioned, having witnessed as a young woman such things as migration of the young to school and work as well as the establishment of the missionary enterprise, continue to emerge, evolve and affect aspects of the TH profession in both the rural and urban areas in diverse ways. The thesis has explored and examined perspectives of traditional healers on traditional medicinal knowledge and its status, its transmission, commodification, commercialization, and its governance. Against a background of general socio-economic transformation in the Eastern Lake Victoria Region, the main focus of the study has been what and how traditional healers in their profession and practices view, perceive and engage in some ongoing socio-spatial processes. The study has looked at TH perceptions on how historical, contemporary actors and organizational structures relate to TMK; the contemporary status, sustenance and passing of TMK to younger generations. The study has examined how processes of commodification and commercialization of TMK and products are perceived by THs of different ages and gender.

In this study THs have told of their perceptions on how urbanization, migration, the commodification of traditional medicinal knowledge, historical changes and dynamic socio-spatial transformations have changed the landscape and increasingly influence the TH profession and practices. Homabay and Mwanza are situated in the Eastern Lake Victoria Region, generally perceived to be peripheral to the respective national contexts. THs’ perceptions are examined in a
temporal, spatial context. Definitions and perceptions have also been examined regarding how they view global processes affecting TMK and how these in turn influence the youth and the general population’s access to and views on TMK and the TH profession.

In this chapter, I present the main findings of the study and thesis. I initially discuss the findings in relation to the status and sustenance of intergenerational learning and transmission contextualized within the worldview of TMK in the study area. I then discuss the commodification and commercialization of traditional medicinal knowledge and products in the light of global processes influencing the practices of younger THs, who are increasingly mobile. I then discuss the findings in relation to historical and contemporary actors and organizational structures that display power relations in the area of TMK and how they interact within the formal and informal arenas.

International research and organizations have examined and described the contributions of traditional medicinal knowledge and practices for both rural and urban populations. Previous studies have examined and documented the medicinal properties of different plant species in indigenous health systems within ethno-botanical, anthropological, zoological and biomedical contexts. Research on the nature of traditional healing, its pragmatic and spiritual basis as well as conditions for its co-existence with modern medicine in a developing country have become serious objectives of study (Beck 1981, Battiste et al. 2000, Agrawal 1995, Eyssartier et al. 2008, Oguamanam 2006, Langwick 2008). It is in the nature of TMK and its practices that they are embedded within wider indigenous knowledge systems with spatial, temporal and place-specific dimensions.

As seen in this study, traditional medicinal knowledge maintains its popularity and continues to play a key role in primary health care in communities in the Eastern Lake Victoria Region in both urban and rural spaces. What dominates THs’ perceptions are the increasingly important roles played by socio-spatial processes such as migration, urbanization, commercialization and habitat degradation in modifying TMK’s learning practices, uses, management, and
aspects of commercialization and commodification. The global historical legacies of colonialism and other global contemporary challenges influencing this knowledge system are clearly seen in the perceptions and voices of traditional healers and other respondents, which reflect the changing societal dynamics affecting their profession and TMK as a knowledge system.

This study uses methodological approaches that navigate THs’ perceptions as well as their views on the norms, systems, attitudes and behaviours that constitute TMK. Through interviews and observations, the study appreciates the exclusively oral and tacit nature of TMK in the study area; the closely guarded and protected nature of the knowledge that renders it difficult for researchers to access and that requires careful methodological considerations and approaches. As I earlier discuss, while throughout the fieldwork discussions I was considered an insider, I argue that I was simultaneously an outsider in the local context. Striking a balance while negotiating my role as a researcher with an insider-outsider identity presented a challenge and sometimes dilemmas, for instance as to whether I had sufficiently ‘distanced’ myself from the THs and the voices in the communities. Through this study I attempt to participate in an alternative evolving epistemological paradigm of approaches and interpretive writings - as discussed by Fatnowna et al. (2002) on traditional medicinal knowledge, based on voices and perceptions of the ‘knowledge owners/holders’.

This study offers a contribution to the understanding of the struggle and contested arena between traditional medicinal knowledge and ongoing socio-spatial dynamics and processes that are influencing its uses and management. It offers a voice for the renewal, reclamation of traditional medicinal knowledge systems, as well as the revitalization of cultural practices related to health knowledge, including the role of propriety of traditional medicinal knowledge held by THs.
10.1 Traditional medicinal knowledge – the status and sustenance of intergenerational learning and transmission

The study shows that the main forms of transfer of TMK are through inheritance, one’s own illness, dreams and spiritual calling, learning by doing and ‘being sent’, while oral narratives and pedagogies predominate, as I saw in discussions with Dani and as Mirambo (1999) discusses about the Sukuma, as well as Battiste et al. (2000), within an aboriginal pedagogic research context. The young individual’s ability to inherit is acknowledged at a pre-puberty age, commonly occurring from an older male or female to a younger male or female. In other words, the transfer of TMK from the older to the younger generation is independent of gender. The majority of THs seem more to emphasize the role of the call for an individual, defined through specific characteristics he/she has, that can enable the acquisition of the knowledge and profession, rather than the individual person’s gender. The young individual’s knowledge acquisition is seen as a gift or a calling which he/she voluntarily accesses. In the study we find individuals who, due to prolonged illness, receive treatment and are cured over a period, and upon recovery continue to learn more about TMK and eventually begin practising as a TH. These groups of apprentices were usually older, and their perceptions surrounding the role of the call/gift and related characteristics varied. This later revealed interesting comparisons between THs who had acquired TMK at a young (pre-puberty) age and adults who had acquired and learnt it after a prolonged illness. I discuss this more in the next section in relation to the gift and commodification. Through dreams and spiritual calling, the apprentice acquires the ability to identify and administer TMK through messages received in dreams. Learning as a form of acquisition of TMK occurs post-puberty or in adulthood, and in the study we find cases of adult-to-adult transfer of TMK as well as teaching of a spouse or an apprentice from another community/region. For the majority of respondents, particularly rural-based THs, I find TMK learning taking place through vertical transmission, as discussed by Eyssartier et al. (2008), while for a minority it takes place through horizontal transmission. This reveals that intergenerational learning of TMK between generations, within genealogy, still has a wider space in the study area even though TMK learning still occurs between individuals of the same generation irrespective of their relationship. The
‘educator’ and ‘learner’ among the majority of respondents have a familial relationship, though non-familial relationships were also common, particularly in the Mwanza study area. Gush’s research (1999) argues that intergenerational relations and learning programmes on an entirely non-familial basis - as one approach to intergenerational programme learning - is next to impossible. However, I find intergenerational relations and learning/transmission of TMK between THs and individuals on an entirely non-familial basis among some respondents in Mwanza and Nyanza. Both female and male young apprentices from other regions of Tanzania travel and reside with rural-based younger male THs in village hospitals in Mwanza to learn TMK. For instance, a younger male rural-based TH in Nyanza had learned his profession in another country after a prolonged illness, which was characteristically on a non-familial basis.

Prayers, rituals, oral narratives, ‘being sent’, ‘learning by doing’, and preservation and storage techniques are central components in the learning process of TMK. Similar to indigenous pedagogy, TMK learning places attentive value on the apprentice’s ability to learn independently by observing, listening and participating with a minimum of intervention (Battiste et al. 2000). The learning and forms of transfer are embedded in intense reciprocal relationships and mutuality over a long period, which provides apprentices, who later become THs, knowledge in a number of specialized categories or fields of TMK, which are interdependent. For instance, a traditional birth attendant was observed to combine this with being a bonesetter and an herbalist in the Nyanza area, and a diviner was seen to combine herbal treatments and bonesetting in the Mwanza area. The specialized categories or fields within traditional medicinal knowledge are not solely exclusive; rather, they are often interdependent, and some traditional healers may hold a number of specialized knowledge of TMK. In other words, as Fatnowna et al. (2002) point out, indigenous knowledge learning and transmission are heterogeneous, but with distinctive compartments accessed depending on who is to be taught, at what age this occurs in their life course and what subject or purpose it is for. Concurrently, TMK transmission within contemporary indigenous life draws distinctions between sacred knowledge and readiness for it, depending on age and maturity (ibid).
In the study we see the THs’ cosmological worldview of illness and well-being, whereby illness is perceived as a social concern with treatments being patient-centred while attempts are made to heal the spiritual aspects of it. Here I find the holistic worldview, described by earlier research, entailing reciprocity, mutual relations between humans and nature within kinship relationships among people, the land and the cosmos, from which knowing originates (Ermine 1995). An emphasis is placed on the importance of the social space, with respondent THs defining their role and place as the medium through which TMK as a gift is channelled in providing service to the community. The place and spatial dimensions in TMK knowledge transmission, according to TH perspectives, suggest that it is tied to specific landscapes where learning rituals and ceremonies occur. The temporal and place-based dimensions of intergenerational learning, discussed by Gadsden et al. (1996), Battiste (2002) and Morphy (1995) are reflected here, whereby TMK learning is maintained and tied to landforms and community settings, which I see in the empirical perspectives of the THs in Mwanza. Maintaining the integrity of the land itself (Battiste 2002:13) is an important component of learning rituals and techniques for harvesting plants, most of which are increasingly accessed at distant places. It is the duty of the traditional healer to act as a medium through which this gift is shared with individuals within the society who may need it. This study reveals the characteristics of an apprentice such as ‘doing good’ which are defined as central, while THs only teach TMK apprentices they perceive to have a ‘good nature’ and empathy for their fellow human beings. Battiste et al.’s (2000) view on TMK learning is that it is a living process that is absorbed and understood through lifelong responsibilities that help individuals understand the world around them and animate their personal responsibilities.

Among the respondents there were younger male urban and rural-based THs in Nyanza who cited alternative approaches, including the increasingly diverse acknowledgement by the youth of learning TMK as a livelihood strategy. Researchers based in the urban space indicated that the youth express interest in learning the profession as a livelihood strategy. Younger male and female urban-based THs in Nyanza indicated a zeal for intergenerational learning of TMK by the youth in parallel with modern medicine. This view was expressed by
respondents, who themselves had a secondary school education and discussed some perceived advantages of combining a formal, conventional medical education with learning TMK. According to them, they taught TMK to their own children, who were combining work at formal hospitals and as THs. On the other hand, in Mwanza we found sons of older rural-based male THs who had discontinued their secondary school education and were working with/learning TMK as apprentices at the village hospital. The perception was that the apprentice sons saw the large volume of work/beneficiaries their fathers had, and wished to learn how to inherit the TMK and help. Here again is the model of learning to combine formal education with TMK learning. Combining formal education with TMK learning by apprentices and THs, as discussed above, provides what Kenner et al. 2007 call a relationship of mutuality between the two generations, which could lead to the apprentices developing TMK skills that complement school learning while invoking cultural continuity and change.

Alternative perceptions linked with the access to alternative and diverse knowledge and views on how to learn and how to survive - in both the rural and the urban space - may well be increasingly important in an alternative worldview whereby rural and urban TMK learning meets urban and rural educational and global learning alternatives.

The older (and some of the younger) female THs in the Nyanza study area lamented that while some youth view TMK and its learning as their heritage, the interest in learning is decreasing. They indicated the preferences of the youth to access conventional medicinal approaches while regarding TMK as outdated. In the study area in Nyanza, a younger male TH respondent who had been taught by his mother, and whose son had been taught by his grandmother’s younger sister, indicated that the young adult had abandoned this knowledge, “regarding it as useless”. Within the group of older and younger male THs in the Mwanza area of the study there were contradictory views, some indicating that the youth were interested in both learning and accessing TMK. Respondent perceptions by younger and older THs in Mwanza describe the village hospital model, which provides a space and place for the youth to learn TMK, enabling them to set up their own village practices in their home regions on their eventual return. Other narratives among rural-based THs in general suggest that intergenerational
learning of TMK was not popular among the youth, although we see examples of young students and workers from the urban and rural spaces approaching THs for help with ailments.

Urbanization, according to the THs’ perspectives, exposes the youth to an increasingly confronted space with emerging societal views, related to increased mobility and change in social space, while engaging with more heterogeneous population structures in urban spaces. THs define a youthful population with increased mobility and access to urban places and spaces, coupled with comparatively diminishing contacts with THs and TMK spaces. The intergenerational transmission of TMK between generations, which is intimately linked to space, place and temporal dimensions, is increasingly affected by these diminishing contacts between THs and young mobile individuals. All THs interviewed discussed rural-urban migrations, which aid in increasingly transforming the youth in their socio-cultural and socio-economic views, including health practices and knowledge related to them. This relates to the assertion by Nesheim et al. (2006) that migrants’ adaptation to new social economic and natural environments that challenge their beliefs, values and knowledge exchange systems, including their recognition and use of natural resources, can involve many aspects of their lives. Their view is that the causes of urbanization are complex, while migrants may bring knowledge and practices that are new to the area of arrival. The youth who migrate to other regions upon completion of their apprenticeship in Mwanza could bring health knowledge they have learnt to their areas of origin. Other youth, according to the THs, may seem to be increasingly engaged in a social space that merges alternative views on learning systems with alternative livelihood opportunities, which may relegate TMK learning to a contested platform. My view is that the learning of TMK seems to be evolving within a dynamic space where livelihood sustenance, which is closely influenced by globalization processes within a market economy, increasingly defines the space of this learning in youths’ strategies. It is learned in combination with medical training, or at a village hospital, to allow the individual to later set up a practice. My view, based on the THs’ perceptions, is that TMK and TM are seen to adapt and flourish in both urban and rural spaces, which shows the dynamic and flexible nature of TMK as earlier discussed in the study.
The slow erosion of TMK teaching and related intergenerational learning processes, which THs refer to in their discussions, is generally in parallel to and partly a consequence of prolonged periods of the youth being engaged in formal education. As mobility and migration increasingly separate the older and younger generations in time and space, the transmitting role of ‘knowledge keepers’ (THs) increasingly diminishes. I link my findings with Fatnowna et al.’s (2002) research, which describes most Australian aboriginal communities in urban areas, in which elders/seniors express concern and considerable anguish that few young people want to know the ‘old stories’ and that few are seen as sufficiently prepared to have these passed on to them. Australian indigenous knowledge systems and ways of learning have been not only weakened, according to Fatnowna et al. (2002) and Macedo (1999), but also colonized through interpretations ‘about’ aboriginal peoples, while an epistemological resistance has characterized the knowledge transfer and ways of knowing of aboriginal peoples (Odora Hoppers 2002:6). According to Fatnowna et al. (2002), the educational systems that alienate the young generation from the old, such as the residential education model that forced the migration of aboriginal Australian children, also severed the organic link between generations in which mutuality and reciprocity predominate in relationships, which are necessary conditions for learning TMK. In this study the apprenticeship system and its continuity are seen as becoming increasingly ruptured. The THs’ perceptions suggest this within the context of increased urbanization and the movement of youthful populations from rural to urban and rural areas in search of alternative livelihoods, circulatory migration and longer periods away at school of the youth, all of which contribute to altering the amount of time and the distances between the ‘learners’ and ‘educators’ of TMK. In a climate of changing cultural contexts, the passing down of TMK from older to younger generations is being negotiated while TMK values and attitudes are re-evaluated in a context of a space experiencing rapid socio-spatial transformation. Like Battiste (2005), I find that most of the younger urban- and rural-based THs advocate for a combined experience, a respectful way of knowing, entailing a blended educational context that respects and builds on both learning and working with traditional medicinal knowledge and modern formal educational systems of pedagogy. My study shows that learning TMK as a calling or acquiring it as a gift is decreasing, with fewer youth available in place due to
prolonged education away from home, while more and more are simply not interested in learning TMK. However, in both study areas, according to the THs, there are young people who wish to learn TMK as a livelihood strategy rather than solely as a medium through which the gift is channelled in service to communities.

10.2 The commodification and commercialization of traditional medicinal knowledge and products

Some similarities and differences that I discuss in this chapter exist in both countries, in relation to the issues mentioned by the THs that confront contemporary spaces when practising their profession. Most of the THs – younger and older, female and male, rural- and urban-based – indicated that deforestation activities, changes in landscape and land policies have an impact on the access to plant material and ritual places, which are moving further and further away in both the study areas of Mwanza and Nyanza. Their concerns revolve around the need to travel longer distances, coupled with costs incurred for harvesting and gathering TM products, which are no longer abundant or available/accessible locally. Contemporary land policies, which are characteristically more privatized and restrictive, combined with the aforementioned, translate into a need to request remuneration for their services to communities. However, some older and younger female rural- and urban-based THs show an increased awareness of the need to cultivate some medicinal plants on land purchased for this purpose.

Global changes displayed at the local space which links to socio-economic issues, such as increased unemployment, drive youth migration to urban and rural spaces to seek alternative livelihoods in a market economy. These processes are seen by the THs as influencing youth perspectives and attitudes about TH as a livelihood strategy. While the changes, according to THs, increasingly undermine TMK, the youth increasingly view TH as a profession to enable them to sustain their livelihoods. TMK viewed as a gift, and therefore provided to communities irrespective of whether they are able/unable to pay the TH, is increasingly seen as
no longer being a long-term viability, particularly among the young male urban-based THs. However, we do see older female and male THs who provide services irrespective of beneficiaries’ ability to pay. TMK (which is embedded within a gift economy and its related cosmological views) increasingly evolves as it meets a market economy, where neoliberal policies translate into formal health services being expensive for the majority (Mshana 2002), while the downsizing of the formal sector and markets turns populations to the informal economy as a livelihood-diversifying strategy (Helgesson 2006). I view TMK as acquiring a space in the informal economy, described by Bryceson (1996, 1997) as an emerging livelihood strategy for both urban and rural younger male THs and the youth. The informal economy in which TMK is increasingly embedded may be more important for THs who acquired TMK at a later stage in their life, as discussed earlier (having experienced prolonged illness and later learning with a TH to acquire the profession). These THs differed from those who had acquired it at a pre-puberty age. They were characteristically older individuals, though younger in relation to older THs, and viewed TMK as a profession to be remunerated like any other profession. The perception is that TMK, which they had learnt and acquired as a profession, is similar to the profession of any student who had studied at a formal learning institution and should be considered as such. In Nyanza and Mwanza, younger male THs were seen to simultaneously work as traders, selling in the urban space and working as a TH in the rural space. These were mainly younger male THs (38-60 yrs). Throughout this study I have compared some of the perspectives of younger male THs who had been trained to become THs in adulthood with those of the older THs who had acquired TMK in their youth through a relative or at a village hospital (the former an example of non-familial transmission). I find that the latter seem to place more emphasis on TMK’s role as a gift. The older male and female rural-based THs, and younger female urban-based THs who had inherited TMK, had acquired it from a parent or grandparent at an early age. In their narratives, even though their practices are increasingly emerging into the commodification and commercialization of TMK, they emphasized concepts such as “doing good”, “money does not come first”, “to help someone suffering”, “good nature” and “to have empathy for their fellow human beings”. Geissler et al.’s (2002) discussion on intergenerational learning and transmission of TMK in Luo society, which
engages the reciprocity dimension, speaks of a gift economy like that seen in both the study areas, which is still considered important by older and younger female, as well as older male, respondents in the study. These relations, which Nesheim et al. (2006) point out are based on reciprocity and obligations to the community and other life forms, are here still seen to be based on sharing TMK knowledge, meaning and empathy – a people-centred individual, according to Ntuli (2002). This study shows that the innate characteristics required for a young individual to be recruited as an apprentice to work as a TH seem to play a defining role throughout his/her profession as a traditional healer. This study shows that these characteristics serve to mainstream their perceptions and views on TMK as a gift throughout their life course. The THs who had acquired TMK later in their life course and who had acquire the profession after having been healed of an ailment seem to be more engaged with commercialization and commodification aspects of TMK than those who had acquired it as a calling.

I find that the majority of the female respondents were less likely to migrate between urban and rural spaces to work, and were mainly active as THs in the rural spaces. One argument I found for this was that younger female THs (50 and below) were rare. Younger female THs were perceived as more vulnerable to sexual and other dangers if they worked away from their homes, and are less likely to be allowed by their spouses and family to work away from the marital home. Therefore, the predominant age of the female THs was in the older, post-menopausal ages when they had acquired Dani status in the community. The migration patterns in the study area, which is characteristically youthful and male-dominated, in turn reflect fewer female TH migration trends. What emerges is an increasing interdependence between the two paradigms, exemplified in this study when we discuss, for instance, medical pluralism.

The emerging collaboration and linkages seen between the formal and informal health services, as seen in the study area in Mwanza, and the youth training to become both a traditional healer and a conventional doctor simultaneously in the study area in Nyanza, are examples. A younger male TH working as a trader in the marketplace and space meets commercialization and commodification aspects of TMK while at the same time providing services in his homestead. The
cultivation of TM products is increasingly seen as combining aspects of the commodification and commercialization of TM products in parallel with the TH providing services.

While their role in primary health care is to provide service and treat common and chronic illnesses and socio-psychosomatic ailments, the THs’ emerging role treats ailments that are increasingly social and psychological in nature. Dynamic socio-spatial changes linked to, for instance, urbanization and migration translate into bringing geographically and linguistically isolated groups into contact with dramatically different social, economic and cultural settings. In urban spaces we see challenges linked to livelihood-seeking strategies, for instance lack of success in business and employments and marital issues. The urban space involves competition over limited opportunities in an arena where in-migration to the urban space predominates, thus the need for individuals to receive support and services from THs who, according to the prevailing Cosmo-visions, are able to help solve societal problems that are not necessarily directly linked to health and illness but are rather more socio-cultural and socio-economic in nature, as mentioned above. The THs view the commodification and commercialization aspects of TMK as increasingly a means to sustain livelihoods, while urbanization also increasingly concentrates large numbers of heterogeneous populations in place and space where there is correlated increased competition for both Western and traditional medicine. The globalization processes that have gained influence, such as increased commodification and commercialization of more spheres of human life, including treating new health problems, could be affecting and invoking an increased commercialization and commodification of TM and TMK within what Gibson-Graham (2006) terms a global market economy that is shaping (and equally shaped) by diverse local economic realities. The reinvention of traditional socio-cultural practices in order to deal with the challenges of contemporary urban life (Laurenco-Lindell 2002) may entail a reinvention of TMK. What may be left is to find dynamic alterations within the gift economy influenced by these processes in order to fit market demands. This is an evolving arena for the TH to engage his/her services, in the role of one having the gift. This study shows that the gift economy, which is largely non-monetary and based on reciprocity and mutuality, (Swantz 1996), is converging within an urban space.
with new types of health problems. Traditional medicinal knowledge can be said to be experiencing a migrating, shifting paradigm from an indigenous medical system based on a gift economy to become a health commodity for local and global consumption. A monetary economy based on wage economies and other complementary livelihoods means that the gift economy to which older and younger female urban and rural-based THs ascribe may no longer be viable as a sustainable means of livelihood. Traditional healing has increasingly become simply one profession among others.

The empirical discussion highlights an increasing diversification of the TH profession. Although research shows that THs are also involved in agriculture and other livelihood activities, our study further highlights this dimension of the livelihood diversification debate whereby agriculture is combined with farming, formal employment is combined with business, and traditional healing is combined with business or a formal career. The THs are increasingly becoming traders and vendors, which some argue could contest the authentic role of having the gift.

The study defines global processes, with scholarship describing a history of the marginalization of IK, for instance IPR regimes that are embedded in contemporary market dynamics that increasingly meet the local context, reflecting the historical and contemporary encounter between Western biomedicine and traditional medicinal knowledge, as discussed by Agrawal (1995) and others. The wealth of theoretical writings that embody the epistemic divide between traditional medicinal knowledge and Western biomedicine is displayed in the form of contested encounters between female and older THs who emphasize and view their profession as a gift and call while others increasingly view it as a commodity.

Some forms of evolving cooperation between formal and informal organizational structures are noted in the study. Fatnowna et al.’s (2002) scholarship notes that an amalgam of Western and aboriginal medicinal knowledge exists in urban settings, while in remote rural areas the complementarity between TMK and Western treatment practices is significant. Crossman et al. (2002) also note that
plural knowledge systems and practices are undergoing a fundamental shift with an aim of mutual decolonization, as they draw on knowledge learning systems from other worldviews including the Chinese, Ayurvedic, Balinese, Japanese, Arabic and First Nations, thus forcefully affirming their specific epistemologies and cosmologies, including ethical and ecological concerns.

Concerns by THs who raise their vernacular knowledge to claim property rights to their TMK are also seen in the study. This indicates a contested arena that challenges the worldview in which TMK’s socio-cultural context evolves, whereby the TMK of communities is held in perpetuity, in parallel with the formal IPR regimes that thrive within a market economy. The study shows that younger male THs are more likely to view TMK as both a profession and a trade in products, of which they have propriety knowledge. I see this as caused by the migration of predominantly young male migrants from rural to urban spaces in search for alternative livelihoods. TH is increasingly viewed as a livelihood in both rural and urban places.

Emerging views also indicate that THs increasingly view their knowledge as propriety within dynamic rural and urban spaces. The role of actors like the church and governmental organizations who access their services provides a contested arena where TH services are informally accessed by the formal actors but are formally negated in both the Kenyan and Tanzanian sub-study areas.

Intellectual property rights issues are increasingly voiced by the traditional healers who view it as a profession. The increasing scarcity of TM products and plants has meant an increased awareness of the value of TMK knowledge among the THs. Discussions in the study reveal that THs are less likely to share their knowledge for fear of losing customers or of their knowledge being ‘pirated’. My view is that evolving legacies of the gift economy, embodied in practices of TMK, are emerging in an arena where the global meets the local through encounters with the TH. Traditional healers, in response to changes influencing their profession (a consequence of rapid socio-spatial dynamics), contest a space, place and their propriety rights for their knowledge alongside other formal actors working with TMK/IPR issues. The reclamation of the space for TMK may
require a path that could pave the way for the recovery of national, communal identities without which competition on the global market of the ideas and products of TM cannot occur.

10.3 Traditional medicinal knowledge - historical and contemporary actors and organizational structures

The international policy framework in which TMK is anchored, whose inception dates back to the Alma-Ata Declaration of 1978, has evolved into contemporary WHO, regional, intellectual property rights and national policy frameworks. These continue to evolve as they address legislation, policy framework and programmes for TMK in the region, as seen in the two countries.

Traditional healers indicate that historical and contemporary globalization processes surrounding governance structures and organizational approaches to health education have defined, and continue to define, an evolving space and place for THs and TMK in the study area. Colonialism and related global processes in part opened the floodgates for migration and urbanization patterns, which continue to shape the emerging role of TH profession. These processes which influence (d) education and health systems are perceived by THs as continuing to characterize attitudes, views of the youth, communities and formal governance structures regarding TMK. The governance of TMK by formal and informal actors is embedded within a contested arena. The THs and traditional leadership, who governed TMK, according to earlier research (Brandström 1990, Koponen 1998), were more in control of prevailing social and health systems during the pre-colonial and earlier societies than they are today. Their role then in curtailing negative phenomena such as witchcraft and sorcery is well documented, while these phenomena present a contemporary challenge to the formal governance structures and informal organizations in addressing a national/regional problem such as the albino phenomenon. TMK as a resource can be problematic in the Lake Victoria Region, given its transnational and ecological nature. Beck’s (2001) theoretical position on the risks of globalization
changes is that the paradox holds true that states must denationalize and transnationalize themselves for the sake of their own national interest – that is, to relinquish sovereignty in order to, in a globalized world, deal with their national problems. Sorcery and witchcraft combine as a negative vice practised by non-legitimate THs, a threat to the legitimacy of genuine THs in an era when the commercialization and commodification of TMK is on the rise in a region experiencing socio-spatial transformation. The regional dimensions of these phenomena as well their societal cosmo-visions, viewed as an unpleasant reality within communities in the Eastern Lake Victoria Region, would require efforts through legislation and advocacy by both formal and informal organizations. Some examples in the study on emerging forms of collaborative processes, for instance, tie collaboration to efforts to mitigate the HIV/AIDS pandemic. The governments of the countries would benefit from concerted efforts to education and awareness creation in communities on the falsehood of witchcraft, in light of the fact that belief systems and practices exist in various countries. International regimes exist which could support sovereign efforts in combating this societal challenge.

10.4 Mwanza and Nyanza – a brief comparison

It is important to consider the cultural migratory profile of the Sukuma, combined with national policies of decentralization, socialism and governance structures through villagization, including early policy approaches to promote TMK in Tanzania. In recent decades, in literature and respondent views, we have seen relatively more continuity of traditional knowledge learning systems in the study areas in Mwanza than in Nyanza. Migration may enable the continuity of TMK practices with remodifications and renegotiations in space and place.

In the Nyanzan study area, the circulatory migration patterns during colonial, post-colonial and contemporary periods, combined with national policies characterized by the centralization of power to provinces/districts, with less focus on village-level authority, are important considerations. This may partly have

116 Beck applies a theoretical position to the risks of global change, linking threat to ecological, social and economic issues that exemplify his attitude to late modernity.
contributed to a comparative non-continuity and less structure of traditional knowledge learning systems in the Nyanzan study area. The village hospital model in the study was developed in Mwanza and is largely absent in the Nyanza area.

The organizational settings in Tanzania and Kenya differ, with a relatively more successful collaboration between the traditional medicinal organization and formal health care services in Mwanza. Though historically curtailed by the colonial administration, traditional medicinal knowledge in both contexts has experienced different policy climates. The evolving view of the traditional healers after independence in East Africa, which Beck (1981) discusses - whereby a more balanced evaluation of how the \textit{mganga} (TH) was perceived - has continued to influence the socio-political organizations of TMK in the two countries of study, though differently. Tanzania was early in establishing a policy climate to investigate the problems presented by the co-existence of the two health systems. In my view, this study suggests that Mwanza in Tanzania offers examples of how Tanzania, compared to Kenya, has made a more realistic appraisal of the contemporary role of TMK in the communities. The collaboration between formal and informal actors working with TMK in Nyanza is less developed than the framework in Mwanza. I attribute this to the \textit{combined} approaches of learning and education as well as health following the villagization process, which initiated pragmatic ways within communities to redress the inherited colonial imbalance and later national policy to address health in communities nationwide.

Examples in Tanzania that clarify the differing policy climates include: the 2003 Tanzanian Health Policy, which mandated the Village Community Government to appraise, assess and recommend particularly local traditional practitioners for registration; ongoing national governmental efforts to give traditional medicine legal status; pragmatic efforts to professionalize traditional healing practices in Tanzania, according to Langwick (2008); the earlier establishment of the Institute of Traditional Medicine in Dar es Salaam; and TMK being anchored within the health sector in Tanzania while being anchored within the cultural sector in Kenya. The study suggests that the different sectors where TMK is embedded in the two countries could partly explain the different levels of
collaboration between informal and formal actors of health in Mwanza and Nyanza. Empirical evidence suggests that TMK anchored within the health sector has provided actors within TMK the space to engage with the formal health sector. In Nyanza, however, TMK is embedded in the cultural sector, which is perceived as problematic by TH organizations and individuals. Contemporary governmental efforts are underway to grant traditional medicine legal status through policy framework and advocacy measures.

Traditional healing in itself is becoming a more diversified profession with two main spaces, one in the rural and one in the urban – the rural being the space where the plants come from and where gifts are still being used as the mode of expressing gratitude. The urban is where the products are sold, and where treatment is also commercial. There is a generational aspect here, whereby the younger healers tend to be more urban-based and commercial. THs are increasingly mobile, in search of plant raw material as well as clientele who can afford their services. One TH in Tanzania lamented that he needed to travel further and more often, as beneficiaries in the local community did not pay well for his services. An export orientation and the commercialization of agriculture, as argued by Feierman (1986), are two aspects of change regarded as development in Africa with a mastery over the environment. This is development, he argues, which sees the managers of therapy losing some of their control over the social environment of health. This combines with the general subjugation of alternative cosmological worldviews initiated by colonialism, which continues in the neoliberal era, as shown in the study.

10.5 Some gender dimensions

In this study I consider gender to be an important dimension of how TMK is passed on between older and younger generations in different places, for instance who is taught by whom, which in turn is influenced by gender norms and gendered patterns of migration and labour markets. The study shows that evolving global processes such as the commodification of land and market forces increasingly putting pressure on wage economies, forcing individuals to diversify their livelihoods, have gendered dimensions. Economic challenges dictate
gendered migration patterns, which translates into predominantly younger male THs migrating to urban spaces to work with their profession. Female THs were mostly rural-based in the study.

In my study, traditional medicinal knowledge for traditional birth attendants (TBA) is predominantly organized and transmitted by female traditional healers. I found this done by older and younger female THs. This relates with Husinga et al.’s third characteristic, whereby gender attributes of local knowledge are compared between men and women.

I also found that the TBA profession, which is embedded in strong socio-cultural dimensions associated with fertility and childcare, is mainly transmitted from mother to daughter, but also from mother to son. A TBA combines within her/his profession other treatments for common ailments in the community. Luo plant medicine has been argued to be mainly a domain of women’s activity, due in part to the nurturing role of women in the first stages of life (Olenja 1991, Geissler et al. 2002). This study shows that in the study region, both male and female Luo and Sukuma THs engage in TMK learning processes and practices as well as the increasingly evolving arena of its commercialization. I found in my interviews that the three major forms of becoming a traditional healer – inheritance, one’s own illness and having a calling - are not gender-specific.

A large number of urban-based THs who increasingly organize their TMK around its commercialization are predominantly male, while female THs organize their profession around the ‘new’ homestead to which they migrate when they marry. However, there are some differences between the study area in Nyanza and Mwanza (as discussed in the previous chapter), which I explain as differences in perceptions, as well as a village hospital primary health care model with traditional healers (female or male) as heads of the village hospital, seen only in Mwanza, Tanzania.

The urban commodification and commercialization of TMK involves migration, which is easier for younger male THs, as seen in my empirical work. We found that older female THs are more prone to view TMK in light of the gift and its role
within the gift economy. They have an added emphasis on TMK as something that should be used to treat and heal, irrespective of whether some financial or other gain from the services is rendered. It was interesting to note, however, that gender was not as important in knowledge transmission as were the characteristics required for an apprentice to be ‘selected’ to acquire TMK. Irrespective of whether the individual is a female or male, the most important aspect is whether he/she has the characteristics required to be able to provide service to communities, which I discuss in detail in Chapter 8.

What seems critical in the countries of the study, however, is the need for closer and pragmatic cooperation on policy between formal and informal organizations working with traditional and modern medicine. An end result and goal to partly solve the existing health and social problems discussed in the communities of the study could increasingly involve those legitimate traditional healers whose knowledge has survived and continues to be anchored within dynamic social spaces. The legitimate TMK holders and managers could be involved with strategic collaborative support, as the study shows that they are well placed to proactively participate in providing diverse solutions in a region that is in the midst of extremely dynamic socio-spatial transformation, as is the case in the Eastern Lake Victoria Region. THs and the medical health services alone cannot solve these challenges, as they constitute political, managerial, governance and social definitions just as they are problems of the medical sector.

10.6 Conclusions

The legacy of colonialism and the introduced education and learning systems that were a part of the project that generally regarded non-Western knowledge and particularly TMK as obsolete is found in organizational and societal perceptions of TMK, according to the TH perceptions in this study. The wealth of theoretical writings by, for instance, Mshana (2002), Agrawal (1995), Krishan (1995) and Odora Hoppers (2002) that analyse the differential epistemic and paradigmatic views between TMK and Western scientific systems are seen to relate to TH perceptions. In Mwanza and Nyanza, younger and older male THs discuss a prevailing contested arena for TMK learning and practices against formal
structures alongside changing perceptions that increasingly emphasize the economic utility of plant medicines, which Oguamanam’s thesis (2006) describes. This is a paradigm view which translates into an increased commodification and commercialization of TMK and a decreased interest in learning TMK as a gift alongside the cosmo-visions attached to it. Visvanathan (1997) and De Sousa Santos’ (2007) thesis advocate and propose ethical, moral and cognitive spaces that could enable the emergence of constructive dialogue between societies and knowledge, and in this case TMK knowledge holders and formal organizational structures. The THs advocate for a wider space in organizations and policy arrangements for diverse knowledge, in this case TMK knowledge learning, in order to have a space in wider globalization processes.

The empirical evidence shows a general advocacy by some formal research organizations for the inclusion of THs and TMK content in mainstream research for medicinal knowledge. This argument provides for reforms that could enable linkages between the two schools, enabling them to better and more effectively serve communities. The thesis calls for a complementary approach as a basis for reform and a way forward – an extension or expansion of an already existing form of partnership between formal organizations and informal THs and related organizations. The convergence of these knowledge systems in creative interconnections in research development and teaching could enable each system to preserve its own integrity. Such converging partnerships could enable an outreach to numerous THs, whose knowledge on TMK, worldviews and values continue to sustain health practices in communities in the Eastern Lake Victoria Region. Such partnerships could be instrumental in curtailing the negative practices discussed in this study and related to TMK that are increasingly emerging due to changing dynamic societal processes related to mobility, increasing urbanization trends and the related commodification and commercialization dynamics of TMK in the urban and rural spaces.

The two country contexts have frameworks that have been set up to address the issue of access and benefit sharing, although at the time of the study this was not yet actively implemented in the local context within the TH organizations. However, there is still a need to increasingly invest in the development of skills to
manage IPRs and forge influence for the benefit of TMK holders. Local communities and organizational structures in the empirical area lack the knowledge and systematic mechanisms to safeguard their collective property, in an IPR system whose origin is in very different cultural values and attitudes.

The crux of the matter in the commodification of TMK is that the existing IPR and patent regimes, the economic sustainability and livelihoods within numerous traditional communities, and the unequal power relations between them and market forces, including high costs of litigation – as seen in the study – ensure the maintenance of the status quo; i.e., making it virtually impossible to protect TMK IP.

One of the formal institutions in the study is approaching the future with a focus on issues of commercialization and policy direction through strategies of promotion of and work with traditional healers and their organizations in areas including training, organization to promote trade and promoting traditional medicine in Eastern Africa. In my view, work towards improving the livelihoods of the youth, THs and the communities in the rural and urban spaces through TMK as a profession should revolve around any power they wield in their TMK while endeavouring to develop a space to negotiate within existing IPR and ABS structures.

Traditional medicinal knowledge continues to play a significant role in the provision of primary health care in the study area. With TMK, especially of plants, interlinked with natural resources and the rights of communities and knowledge holders over their knowledge and resources, multiple and interlinked ethical dilemmas and challenges characterize the IP ownership arena. This is further compounded by differences in THs’ concepts of knowledge ownership and by unclear effects of some potentially useful strategies. I argue that official governance structures and policy should view the interlinked and multi-layered issues and challenges, while aiming at providing solutions to the fragile scenario of benefit sharing and IPR regimes.
Colonial intervention created new medical landscapes for communities, by for instance concentrating urban and rural populations and health care and medical services while introducing biomedical technologies. Contemporary circumstances such as HIV/AIDS, climate change and socio-spatial transformation processes are creating new forms of medical challenges, perceptions and practices. The migration and mobility of different actors, activities since the colonial era to the present period in Tanzania and Kenya, have influenced different medical conditions as well as the perceptions of medical therapies, while subsequent post-colonial governmental policies have a defining effect on these medical landscapes. The colonial heritage, including the introduced Western religion and education in the rural and urban areas of the study, may have had a tremendous impact on the role traditional medicine plays. As Western education, Christianity and globalization processes increasingly become an integral part of rural and urban communities, societal taboos within TMK that have provided societal control, for instance over negative practices, traditions and customs linked to TMK, are changing and in some instances have been abandoned altogether. I concur with Feierman (1986), who indicates that the emergence of capitalist relations of production in the city and the countryside, the growth of population, and rapid urbanization have changed the social terrain upon which health care provision is based in Africa. This is the case in this thesis. The emerging neoliberal economic policies in the two national contexts seem to dictate the path towards more marketing strategies for TMK. This is seen in the empirical setting, with the dynamic mobility of younger male THs working within both the urban and rural spaces. In the urban space, female and male THs increasingly operate using TMK to meet primary health care needs, including the sale of TM products for their livelihood. The marketing of TMK and products assumes a wider space in contemporary times, thus transforming the socio-cultural definition of TMK as well as the socio-economic premise upon which it rests.

Within a climate of rapid societal socio-spatial transformation processes, the study defines the increased emergence of alternative health challenges (linked to urbanization, migration and populations seeking alternative livelihoods). It seems that TMK will increasingly address challenges to health and well-being that are more related to how individuals as communities adjust to these
transformations. Adjusting to migrating away from the family to the urban space, luck in finding a job and partner and luck in addressing jealousy in the urban space with its more heterogeneous populace are approaches which the TH profession will increasingly address in both the urban and rural spaces.

The formal paradigm in the study suggests a proactive climate addressing national policy on intellectual property rights and benefit sharing agreements. The aspect of the local meeting the national and global dimensions would be interesting for further research to examine. How does the informal discourse (to which TMK and THs were relegated to during the colonial and post-colonial eras) re-emerge to access the formal space? Can informal perceptions and perspectives of TMK and TH be influenced by pragmatic approaches to IPR/ABS and patent issues for local communities and TH organizations, as we see in the example of the San communities in Namibia/South Africa? This study suggests that future development initiatives which target livelihoods strategies and goals for the youth and THs that do not consider cosmological aspects of TMK may not be sustainable. Much as TMK learning systems are changing, including traditional cosmological aspects, the study suggests that for any development practice to succeed in addressing the health and well-being of rural and urban communities, elements of the role of traditional cosmological aspects of their knowledge need to be addressed.

A wider space for indigenous and traditional medicinal knowledge local perspectives is advocated by this thesis. Official health policy planning at all levels is already providing a place for change to and prioritization of alternative health systems, in this case legitimate TMK. Emerging forms of medical pluralism do exist; within communities, both traditional medicinal and conventional health systems co-exist, with individuals consulting the two systems for different reasons and at different stages of the disease, though forms of official collaborative praxis whereby THs and researchers in cooperation can develop the policy and research agenda are still rudimentary. The adoption of a curative and preventive approach in health planning while employing both traditional medicinal knowledge and Western health knowledge could provide culturally appropriate health care.
Attempts to design linkages between the commercialization, commodification and domestication of TM products would require policy research on TM to extend their conceptual framework and closely review linkages between the environment, markets, harvest and production of cultivated and domesticated TM products (that are traded in the market space) as well as social health and well-being in communities as viewed by traditional healers.

A central question during the interviews with THs was how young people will be taught in the future. Although complex political discussions prevail, I view a proactive development of economic livelihood incentives for the youth as key to sustaining the learning processes of TMK.
SUMMARY

As we celebrate all the dynamic and dramatic improvements in human health care in the 21st century, life in much of Africa begins with and is sustained with the support of traditional medicinal knowledge. Research on traditional medicinal knowledge (TMK) is extensive, but rather few studies have been written about Traditional Healers’ (THs’) own perceptions about TMK and practices in relation to changing societal dynamics.

The aim of this thesis is to examine how THs perceive ongoing socio-spatial transformation, including contemporary processes of urbanization, migration, commercialization and commodification of TMK, as well as changing dynamics of learning and knowledge systems between generations and genders and how these affect their medicinal healing practices in time and space.

The thesis consists of four main empirical chapters, which derive from different data sources including literature, documentation review and qualitative interview material. The findings in this thesis can be summarised as follows: First that TMK today exists side by side with modern health systems, in what are seen as complex patterns of medical pluralism that provide evidence of an evolving role the TH plays in primary health care, in the rural and urban space. Youthful migrating population dynamics that are linked to historical processes, have effectively carved an emerging cross-sectoral role of the TH in the formal space.

Secondly the developing legislation on IPR and ABS in parallel with the representation of an earlier official formal governance around TMK in Tanzania; and the difference in the sectors where TMK is anchored in the two contexts, could have paved way to some earlier collaborative mechanisms, that today provide space to enable a more natural engagement between formal and informal organizations involved in the governance of TMK in Tanzania. Thirdly, the practical ways in which TMK learning processes, which are characterized by learning systems in place, being sent and visiting sacred places that are lived by an apprentice over a number of years, have increasingly come under pressure.

Fourthly the thesis shows approaches by THs, encouraging the youth to access conventional medicinal education followed by, or in parallel with TMK learned
through traditional pedagogies employed by the THs themselves. The youth’s keen interest in learning TMK is seen to increase when they view improved livelihood possibilities due to the commercialization of medicinal plants. The future of TMK learning processes may be limited unless incentives are put in place for the youth regarding their future livelihoods. Fifth, gendered and generational dimensions suggest that older and some younger female THs re-emphasize the values of the *gift* and TMK in a climate of increased commodification and commercialization of TMK, where TMK increasingly meets neoliberal processes, engaging an alternative paradigm than the gift economy, where a predominance of male TH’s in the urban space and places, increasingly define the diversification of the TMK livelihoods. The gift provided by a higher power and which is embedded in a particular cosmological view, to be used as a social service to help the community, is increasingly evolving as an emerging tested force in a changing ideological climate, with an increasing awareness of commodification, commercialization, IPR and ABS issues surrounding TMK. It implies awareness in relation to the increased benefits of commoditized and commercialized medicinal plant knowledge (which THs hold) for other individuals and institutions.

The TH profession and TMK is seen as entering a contested IPR/ABS arena at a time when increasingly socio-spatial transformations are modifying its role from that of a gift to an owned commodity. However while the practice of TMK has changed over time and space, presenting new challenges as well as opportunities, it is also seen as a threat that anyone today can sell and market TMK products.
MUHTASARI

Tasnifu hii imeshughulikia Maarifa kuhusu Tiba za Asili na Mabadiliko ya Kijamii katika ukanda wa Mashariki mwa Ziwa Victoria. Huu ni utafiti wa kitaamuli uliojikita katika ukusanyaji wa data kwa njia ya mahojiano na Waganga wa Tiba za Asili pamoja na watu kutoka katika taasisi mbalimbali nchini Kenya na Tanzania. Lengo la utafiti huu ni kuchunguza namna Waganga wa Tiba za Asili wanavyoyatazama mabadiliko ya jamii yanayoendelea kutokea na yanavyoathiri taratibu zao za tiba za asili kulingana na mahali na muda husika. Jambo moja kubwa miongoni mwa yaliyoshughulikiwa ni namna Waganga wa Tiba za Asili wanavyolitazama suala la kurithisha maarifa hayo ya uganga kwa vizazi vichanga/vipya.

Maswali ya utafiti ni:

- Watendaji na miundo ipi ya taasisi (rasmi na isiyo rasmi) iliyokuwapo kihistoria na iliyopo sasa inahusiana na Maarifa kuhusu Tiba za Asili na vinatazamwaje na Waganga wa Tiba za Asili?

- Waganga wa Tiba za Asili wana mtazamo upi kuhusu hadhi ya Maarifa ya Tiba za Asili na hali ya kuyafanya yawe endelevu na kuyarithisha kwa vizazi vichanga/vipya.

- Taratibu za urekebishaji na uuzaji wa bidhaa zinazotokana na Maarifa ya Tiba za Asili zinatazamwaje na Waganga wa Tiba za Asili wa umri na jinsia tofauti?

Utafiti kuhusu Maarifa ya Tiba za Asili una mawanda mapana, lakini, kazi chache zimeandikwa kuhusu mitazamo binafsi ya Waganga wa Tiba za Asili dhidi ya Maarifa ya Tiba za Asili na taratibu zake kuhusiana na mabadiliko ya kijamii. Hata baadhi ya kazi za hivi punye kuhusu maarifa ya asili na haki miliki hazikutilia mkazo kwenye mawazo na mitazamo mbalimbali inayoweza
kupatikana katika uwanda huu, kwa mfano, mkazo umewekwa zaidi kwenyenjazi ya chini kabisa kwenyenjazitazamoya Waganga wa Tiba za Asili wenyewe.

Mabadiliko ya kijamii yanahusisha taratibu za kuanzishwa kwa miji, uhamiaji, ubadilishaji na uuzaji wa bidhaa zinazotokana na Maarifa ya Tiba za Asili, pamoja na mabadiliko ya ujifunzaji na mfumo wa maarifa kati ya vizazi. Kupata taarifa taarifa kutoka kwa Waganga wa Tiba za Asili kunaweza kuwa changamomo, kwa sababu taarifa na maarifa kuhusu utaalamu wao hutolewaka kwa mdomo. Maarifa haya kwa kiasi kikubwa hayajuandikwa, yanafichwa na kutolewa kwa watu wachache.

Tasnifu inachunguza ubadilishaji na uuzaji wa bidhaa, uanzishwaji wa miji na mabadiliko katika mfumo wa mwingiliano wa ujifunzaji na maarifa ya vizazi pamoja na jinsia.

Michakato ya kijamii, ambayo ninaiita pia mabadiliko ya kijamii, yana athari kwenye Maarifa ya Tiba za Asili, na matokeo ya utafiti yanaonyeshamnamna Waganga wa Tiba za Asili wanavyoitazama michakato hii: namna michakato hii inavyoathiri taratibu zao, namna wanavyohawilisha maarifa toka kizazi hadi kizazi, na namna wanavyoelewa hali ya ujifunzaji wa taratibu hizi. Lengo likiwa kuchunguza namna Maarifa ya Tiba za Asili na taratibu zake vinavyopata changamomo, mabadiliko na/au kudunishwa na mabadiliko ya sasa ya kijamii.

Maarifa ya Tiba za Asili yanaweza kueleweka kuwa ni maarifa yaliyomo kwenyemaarifa ya asili na mfumo ya kiimani, yanayoweza kupimwa kwa vigezo vya nafasi, muda na mahali, na yanatumiwa na jamii ziishizo mijini na vijijini. Kutokana na mbinu zilizotumiwa na baadhi ya watafiti pamoja na Shirika la Afya la Dunia, katika tasnifu hii, ninatumia nadharia ya Afya inayoweza kusawiri kwa pamoja maarifa ya kimagharibi ya tiba na yale ya kiasili kuliko kuyaangalia mambo hayo kama yanayokinzana.

Tasnifu hii inaundwa na sura kuu nne za uchanganuzi na uwasilishaji (6-9) ambazo zimetokana na vyanzo mbalimbali vya data: sura ya 6 imetokana na taarifa za upitiaji machapisho na nyaraka, pamoja na mahojiano yaliyofanywa
kwa lengo la kupata taarifa kuhusu utendaji na ulewa wa Waganga wa Tiba za Asili; ambapo sura za saba, nane na tisa zimetokana na taarifa za zilizojikita kwenye mahojiano na watoa taarifa wanaofanya kazi katika nafasi mbalimbali za uongozi pamoja na Waganga wa Tiba za Asili na wakati wa taasisi zilizoko Nyanza na Mwanza. Sura ya 6 inawasilishia mukadha wa kuendelea kukuwa kwa nafasi ya Maarifa kuhusu Tiba za Jadi, ikitoa muhtasari wa halii ilivyokuwa wakati wa ukoloni kama usuli wa muundo wa uongozi na mikabala ya mipango ya afya, elimu na Maarifa kuhusu Tiba za Asili pamoja na michakato hii ambayo inawezekana ilisababisha na inaendelea kuzipa umbo tafiti za sasa za Maarifa kuhusu Tiba za Asili. Mwingiliano kati ya mijadala katika medani za kimataifa kuhusu upatikanaji na kugawana faida na mifumo ya miliki za kitaaluma unajadili wajibu wa watendaji mbalimbali na nafasi walizo nazo katika ngazi mbalimbali za kidunia, kitiwa na kienye zinazosimamia Maarifa kuhusu Tiba za Asili. Mataokeo ya sura hii yanaonesha kwamba Maarifa kuhusu Tiba za Asili kwa sasa yapo sambamba na mifumo ya sasa ya afya katika kwenye mulimu kama mifumo changamani ya wingi wa tiba. Inaonesha kuwa katika nechi zote mbili utungaji wa sheria kuhusu masuala ya mifumo ya Haki Miliki za Kitaaluma na Ufani na Ufani na Uganda na Na Maasai kwenye kujenga hoja kwamba uchangamani wa tiba nyingi uliopo katika eneo la utafiti, unatoa ushahidi tosha wa Waganga wa Tiba za Asili inayoendelea kukua katika

Sura ya 7 inachunguza uhusiano kati ya taratibu rasmi za zisizo rasmi za kiuongozi zinazohusiana na Maarifa kuhusu Tiba za Asili. Inatamatashwa namna watoa taarifa na washiriki wa taafiti wanaongeli anja ngazi mbalimbali za kiuongozi zilizo na zisizo rasmi ambazo kwa viwango tofauti huelekea matumizi, usimamizi na ujifunzaji wa Maarifa kuhusu Tiba za Asili. Tasnifu inajenga hoja kwamba uchangamani wa tiba nyingi uliopo katika eneo la utafiti, unatoa ushahidi tosha wa Waganga wa Tiba za Asili inayoendelea kukua katika
huduma za msingi za afya kabi na wao huduma za tiba katika hospitali mijini na vijiji wanaotumia tiba za kisayansi. Zaidi ya hayo inajenga hoa kwamba vijana ambapo sehemu yao kubwa ndio wahamaji katika maeneo ya mijini na vijiji, uhamaji huo unaohusiana na michakato ya kihistoria, ukichagizwa na ukuaji wa miji una taathira kwa Maarifa kuhusu Tiba za Asili katika kutoa michakato endelevu ambayo inaelekeza dhima ya kuhitajika kwa Waganga wa Tiba za Asili na TBA katika maeneo ya kisayansi katika hospitali. Inajenga hoa kwamba usimamizi rasmi wa maeneo wa Maarifa kuhusu Tiba za Asili nchini Tanzania unataka kuwepo uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mtu akipo kati ya au rasmi zinahusiana na uhamaji wanaotumia tiba za kisingatia dhima ya uhamaji wanaotumia tiba za kisingatia dhima ya kuhitajika kwa Waganga wa Tiba za Asili na TBA katika hospitali.

Tofauti ya sekta ambamo Maarifa ya Tiba za Asili yanahusiana na uhamaji huo unaohusiana na michakato ya kihistoria, ukichagizwa na ukuaji wa miji una taathira kwa Maarifa kuhusu Tiba za Asili nchini Tanzania unaweza kuwepo uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi.

Tasnifu inaonesha njia za kivitendo ambazo kwa hizo michakato ya kujifunza Maarifa ya Tiba za Asili yanahusiana na uhamaji huo unaohusiana na michakato ya kihistoria, ukichagizwa na ukuaji wa miji una taathira kwa Maarifa kuhusu Tiba za Asili nchini Tanzania unaweza kuwepo uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi zinahusiana na uhamaji wa kishirikiano, ambazo hutoa nafasi ya kuwezesha uhusiano mzuri zaidi kati ya au rasmi.
zikifuatiwa na, au sambamba na kujifunza Maarifa ya Tiba za Asili kwa mbinu za jadi zinazotumia na waganga wenyewe. Hata inaonesha ushawishi mbalimbali inaonesha kwamba Waganga wa Tiba za Asili wanaonekana kama wanasisitiza tena amali za sawadi na Maarifa ya Tiba za Asili katika hali ya kuendelea kubadilishwa kwa Maarifa ya Tiba za Asili kuwa bidhaa na kuuzwa kibiashara ambapo Maarifa ya Tiba za Asili yanazidi kifika viwango vya michakato isiyo huru yakitumia mtazamo mbadala kuliko uchumi wa sawadi.

Kijinsia, mielekeo ya uhamaji na masoko ya kazi ambavyo huongoza ukubwa wa wa hamaji wanaume inaonesha kwamba kwa kiwango kikubwa Waganga wa Tiba za Asili wanaume ndicho wengi maeneo ya mijini.

Sura ya mwisho (9) inachunguza namna michakato ya ubadilishaji bidhaa zinazotokana na Maarifa na Tiba za Asili inavyotazamwa na Waganga wa Tiba za Asili katika muktadha wa mabadiliko wa kijamii kama vile uanzishwaji wa miji na ufanyaji biashara katika maeneo ya Mwanza na Nyanza.

Kwa jumla, matokeo ya utafiti katika sura hii yanaonyesha kuwa kizazi kipya cha Waganga wa Tiba za Asili ambao ni wanaume ndicho wengi maeneo ya kwatoto na Maarifa ya Tiba za Asili.

Maelezo yaliyotolewa na Waganga wa Tiba za Asili waliyojipewa kuhusu Maarifa ya Tiba za Asili ni kuwa maarifa haya ni zawadi kutoka kwa nguvu kuu (Mungu) na kwamba majukumu ya Mganga wa Tiba za Asili ni kuwa hautumia zawadi hii kama huduma ya kifaa kama vile uanzishwaji wa miji na kuomba malipo.

Waganga wa Tiba za Asili wameendelea kuwa na ulewa kuhusu ubadilishaji bidhaa, uuzaji, Haki Miliki za Kitaaluma na Upatikanaji na Ugawanaji wa Faida za huduma hilo. Hii inaonesha kuwa ulewa kuhusiana na kuongezeka kwa manufaa katika ubadilishaji na uuzaji wa maarifa waliyonayo kuhusu
madawa ya tiba za Asili kwa watu binafsi na taasisi. Wakati uchumi wa zawadi unatambuliwa kujikita kwenye kunufaishana na kuaminiana pande mbili, uchumi unaozingatia soko umejikita katika kulimbikiza faida na kuongeza utajiri. Maarifa ya Tiba za Asili, kwa imani yake kuhusu utamaduni wa mambo yasiyoonekana yaliyojikita katika mtazamo wa kiulimwengu (zawadi), yamekuwa yakiendelea kupanuka kama kani inayojaribiwa kwenye mazingira ya kiitikadi yanayobadilika.

Maarifa ya Tiba za Asili kama chanzo ca kujikimu kinachovutia zaidi katika maeneo ya mijini kinawea kutazamwa katika muktadha wa watu kuachana na kilimo kutokana na fursa za weledi wa Uganga wa Tiba za Asili na biashara ya bidhaa katika masoko ya mijini na vijijini pamoja kupatikana kwa kipato katika maeneo ya vijijini.

Hata hivyo wakati utendaji wa Maarifa ya Tiba za Asili umebadilika kutegemea muda na mahali, ukileta changamoto pamoja na fursa mpya, unaonekana pia kama kitisho kwamba mtu yeyote leo anaweza kutumia Maarifa ya Tiba za Asili. Taaluma ya Uganga wa Jadi inaweza kuachana na kilimo katika maeneo ya vijijini.

Dhima ya kiutawala ya mifumo ya kichifu ambayo yanaboshia dhima yake kutoka kwenye ile ya zawadi na kuwa bidhaa ya kumilikiwa. Tasnifu inajadili dhima ya uchawi, iliyozidishwa katika wa kuuzwa kibiashara kwa Maarifa ya Tiba za Asili, ambayo inaweza kuunganishwa na, na kwa sehenu inachunguza kupitia baadhi ya matokeo ya mikakati ya kiutawala wakiwa na ukoloni na baada ya ukoloni ikijumuisha upangaji upya wa vyombo vya kiutawala na kisiasa vya jadi katika mashariki ya eneo la utafiti.
nchi na mikoa ya Maarifa ya Tiba za Jadi na ulozi kama yalivyojadiliwa inaweza kutoa nafasi ya kuwa na mbinu bora za utawala na utetezi rasmi na zisizo rasmi.
YOOS MACHUOK

Andika ewi paro midwa fuono tiendeni yango matut kony mar thieth ma mya piny to gi lokruok mar oganda ei alap e imbo mar Nam Lolwe, kotenore gi ajuoke to gi joma nigilony moromo e wechegi mawuok kuom riwruiok mopogore-opogore mawuok epiny Kenya to gi Tanzania. Thor nonroni en mar menyo kaka Ajuoke ng’iyo/ neno lokruok madhi nyime ei oganda to gi kaka lokruognu tuomo yoregi mar thieth ei ndalo kod aluora. Maduung’ achiel kuom bath nonroni en kaka Ajuoke ng’iyo yore mag lorogo lony gi mar thieth ne joma biro kawo kargi.

Penjo moyangi ewi paro midwa fuononi, gin:
- Gin jomage, machon kendo masani manie tijni to gi ere chenro mag okenge mochan to gi maok ochan ewi tije mag lony mar ma nya piny (TMK), to giere kaka Ajuoke ng’iyo wechegi?
- Ajuoke ng’iyo nade chung’ mar lony mar thieth ma nya piny to gi yore mar rito lony gino ne joma biro kawo kargi?
- Ere kaka okenge mag choko kendo keto echiro lony mar thieth ma nya piny to gi gik mawuokie ineno gi ajuoke ma chuo gi ma mon ma hikgi opogore-opogore?

Paro midwa fuoni ewi lony mar thieth ma nyapiny lach, somo to tin mosendiki ewi kaka Ajuoge wegi ng’iyo lony mar thieth ma nyapiny gi timbegi kayiengore e lokruok madhi nyime ei oganda. Kata moko kuom andika ma endalo machiegni ewi lony mar kit piny to gi Ratiro mar Gikeni mag Rieko (IPR) osengalo kata wewo oko kanyakla weche to gi neno mopogore-opogore mayudore e alap ma i.e. somo momanyo kuku wechegi to gi kaka Ajuoke wegi nenogi.

Lokruk mar oganda ei alap oriwo okenge masani mar dak kiboma, dar, loso chiro kod senyo mar lony mar thieth ma nyapiny, kanyakla gi loko lokruok mag puonjruok to gi yore mar lony e kind ogendini. Yudo gi manyo wach moyangore kuom Ajuoke nyalo bed ma ok yot, nikech weche moyangore to gi lony ewi tijgino
to gi kaka otenore kuom oganda malach chiegni tee yudore e wach mar dhok gi dhok.

Lony ainani ose dong’ gi kinda ka pod ok obet e andike kokalo oganda bang’ oganda, ka oume kendo di mang’eny kiloso ewiye mana gi joma tin moyier.

Andika ewi paro midwa fuono tiendeni menyo sanyo, loso chiro, dak kiboma to gi lokruok e yore mag somo to gi ma lony lorgo e kind oganda gi rapog dhako gi dichuo (gender) kaka paro maduong’. Okenge mag oganda koyare ma bende aluongo ni lokruok ma e kind oganda ei alap, ni gi majimbore/mawuok ewi kony korka thieth ma nyapiny to gi kaka itimogi, kendo mafwenyo kuom nonro mara yango kaka Ajwoke neno okengegi: kaka okenge siro tijegi, kaka giloro lony gi ne ogendini maluwo ndlogi (mabiro), to gi kaka giwinjo e gik madwarore echopo yoregi mag puonjruok. Wach momoko en mar nono yore ma lony mar thieth ma nyapiny to gi kaka itiyo gi yudo ng’ukruok, lokruok to gi nyaa kendo/ kata thiruok ebwo lokruoge manyasani ei oganda mantie e alap.

Lony korka thieth ma nyapiny nyalu winjore kaka gima odongo eyo mopangi ei alap malach mar lony ma nyapiny to gi yore mag kido, man gi alap, ei ndalo to gi mise mag kuonde moyangore, kendo mitiyogo go gendini mag i piny to gi mag joboma. Ei andika mar nonro moyiedhini, koluware gi Riwruok mar Ngima Maler e Piny Mangima (WHO), to gi yore moko mag jononro, arwako mang’iyo nyako yore mag thieth maler, ma miyo nyalore kelo kanyakla lony mar thieth mar nyawasungu to gi mano ma nyapimy, moloyo kar kawo ni yore (ariyo) gi ni ok winjre/ oknyal wuotho kanyakla.

Andika ewi paro midwa fuononi opogi e wiye madongo ang’wen (W6-9) mowuok kuom nonro mosany kawuok kounde mopogore-opogore: Wiye maduong’ mokuongo (W6) gedo ewi fuon mowuok kuom andike kendo dok e otese madongo ma loso e wechegi, to gi nonro gi lony ewechegi koyiengore e tije to kod neno mar Ajuoke; Wiye madondo abirio, aboro to gi mar ochiko oyiengore e fuon moyudi kuom nonro motim gi jolony matiyo ne mise mag riwruok mopogo-opogore to gi Ajuoke gi jogo mochung’ ne riwruoge mek gi ei Nyanza to gi Mwanza. Wiye maduong 6 chiwo alap madongore mar thuolo gi kar lony e
withieth ma nya piny (TMK) chiwo neon mag Wagunda kaka chakruok mar mise magriwruok ma nyasani ma rito lony ewi thieth ma nyasani. Wiye maduong’ni yango dongruok mag sigend piny (historia) mowinjore penjo mag nonro, kaka mise mag telo gi yore mag chenro ma imanyogo ngima maler, puonjruok gi lony ewi thieth ma nya piny to gi yoregi manenyalo chwalo, kendo dhi nyime gi undo, loso ma nyasani kuom lony ewi thieth ma nyapiny. Rakruok mantie ekind laruok e manyo thuulo kendo pogo ber to gi kanyakla mar giken mag rieko ka gi loso winjruok ekuonde ma joma opogore-opegore manie wachni omako to gi alap gi kama gi mako e okenge mopogore epiny mangima, e piny to gi e mise mag tiyo alensi modok korka chenro mar riwruok, tayo gi chik matayo lony thier thieth ma nya piny. Duoko mag wiye maduongni nyiso ni lony ewi thieth ma nyapiny ochung’ bathe gi bathe gi yore mag ngima maler manyasani e gima yangore kaka yore mogajore/ tudore mag nywako thieth.

Ma nyiso ni e pinje ariyogi dongruok mar chik e chung’ mar Ratiro mar Giken mag Rieko (IPR] to gi yore mag Pogo Ber (moyudore) - ABS en gima dhi nyime, makmanani Tanzania ne otelone Kenya e keto to gi chuogo bethe loch mar tend piny ma omi tich mar loso yore mar tayo to gi mise mar chik matayo lony ewi thieth ma nya piny to gi kaka log chik oganda tiyogo kendo tayo pok moyudore mar lony ewi thieth ma nya piny, kata obetni chik matayo theith mag manyasi kata rido yore mag usogi pod ok oketi e kwonde ariyo gi.

Wiye madongo 7 nono winjruok mantie e kind mise moyangi to gi maok oyangi mag tayo kotudore gi lony ewi thieth ma nya piny, kotenore kuom mosany kuom joma tiyo kodgi.omenyo kaka jomachiwo wach (jowach) to gi jok moyie duoko penjo gi tiyo kanyakla gi mise mochan mopogore -opogore moyangi to gi maok oyangi, me e okenge mopogore lose kendo tiyogi, tayo gi puonjruok mar lony ewi thieth ma nya piny. Andika ewi paro midwa fuononi mino wach ni gajni mar yore thieth motudore gi mayudore kang’eny e kuonde motimie nonroni, chiwo ranyisi mar dongruok kuom tij ajuoke ei arita motelo kuom ngima maler, ka en machiegni ahinya gi ute thieth to gi jotithet ma nya sani mantie e boma to gi e kor gweng’. Omedo mino wach ni joma tindo manenore e kweth mar dar kadhi e boma to gi kor gweng’ man gi tudruok gi dongruok mar sigand piny koriwore gi dak ma nya boma (kiboma) tuomo lony ewi thieth ma nya piny e chiwo yore mag
dongruok manyalo thedho eyo motegno chakruok mar tich mar ajuoke to gi nyamrerwa (TBA) e okenge mopogore ei Iwasi moyangi. Omino wach ni yo mane otelo moyangi mane oketi mar tayo lony mar thieth ma nyapiny e Tanzania dine oyawo yo ne yore moko mag nywako tich, machiwo thuolo mar loso yo mayom mar winjruok e kind riwruok moyangi gi maok oyangi mantie ei tayo lony ewi thieth ma nya piny. Pogruok ewi okenge mag lony ewi thieth ma nya piny otenore e duonde ariyo (Ngima Maler ie Tanzania, gi Migawo mar Kido mar Oganda gi Dongruok mar Gwenge Kenya), ema nyiso tich kaka ajuoke nyalor rakore gi yore telo moyangore mag piny to gi okenge mokel e gwenge. Wiye maduong mar 8 nono kaka lony ewi thieth ma nya piny iloro e kind ogendini kendo nono yore magpek to gi lokruok e yor puonjruokni e kind ogendini kotenore kuom medruok e dar mar jomatindo kochimo boma to gi lokruok mar ogendinin ei alap, e tiyo gi loo to gi medruok/jiwruok e yore mag ohala.

Andika mar paro midwa fuononi nyiso yore matiyo mag puojurok kuom lony ewi thieth ma nya piny nenore e yore mag dak mar puojurok ma japuonjre thieth puonjore kendo omedo tiegruokne e higni momedere. Lemo kuom nyiseche gi timbe moyiengore kuom lamo koriwore gi puonj e wach, puonjruok kitimo, bedo mayot eote, yore mag kungo gi keno, to gi lek, magi eyore madongo mag puonjruok thieth. Timbe mag puonjruok ei kamoro, kiori togi limo kuonde moyiedhi ne lamo osebedo gi pingo momedere. Andika mar paro midwa fuononi siemoni jomatindo medo hero tiegruok e lony ewi thieth ma nya piny mana ka gi ngi’ye kaka yo manyalo kelo yuto momedere ka luwore gi ohala matindeodonjo e thieth mar manyasi. Andika mar paro midwa fuononi menyo tem ma ajuoke jiwogo yore madhi nyime sani mag puojurok mar jomatindo e yor thieth ma nya sani koluwore gi/kata kadhi kanyakla gi puonjruok lony ewi thieth ma nya piny e yor puonj ma nya piny kaka ajuokego giwegi puonjo. Bet onyiso pek ma yor somo thieth mar manyasi ni go kuom yo ma jomatindo nenogo kata chopogo machiegni gi lony ewi thieth ma nya piny. Ndalo mabiro mar yore mag tiegruok e lony mar thieth ma nya piny nyalor bedo machuok mak mana koketi gik malombo jomatindo e yor nwang’o dak manimba. Koyiengore e pogruok e kind dichuo gi dhako [gender] weche ogendini yudore ni ajuoke ma mine madongo to gi moko mapod hikgi tich-tich nenore ni gimedo jiwo ber mar mich to gi lony ewi thieth ma nya piny elwasi mar medruok e sanyo, kendo ohala kuom lony ewi thieth ma
nya piny kama lony ewi thieth ma nya piny medo tudore gi yore masani mochiwo thuolo mar rwako yo machielo mopogore gi mar mich. Kaluwore gi yore ma pogruok e kind dichuo gi dhako nyiso e dar ni ajuoke machuo temo yombo e lap gi kuonde mag boma.

Wiye madongo 9 nono kaka yore mag sanyo weche lony ewi thieth ma nya piny to gi githieth ineno gajwoke kotenore e dongruok madhi nyime elo kruok mar oganda ei alap machalo kaka dak kiboma to gi ohand thieth e Mwanza gi Nyanza. Kiriwo, duoko mag wiye maduong’ni nyiso ni ajuoke machuo matindo ema oteloe/chiko yor manyo ngima mondisore. Thoth ajwoke mane otimnegi nonro loso kuom lony ewi thieth ma nya piny kaka "mich mawuok kuom teko moa malo ma tich mar ajuoga en mar tiyo gi michni eyo mar konyo oganda maok owinjo oketie kwayo chul ayanga”.

Ajuoke medo ng’eyo yore mag sanyo ohala, Ratiro mag Giken mag Rieko [IPR] to gi Yore mago Pogo Ber moyudore (ABS) weche moluoro lony e thieth ma nya piny, ma nyiso ng’eyo modok korka medruok e ber mar sanyo gi keto e chiro [uso] ne jomoko gi kuonde lony ma gin go kuom’fnanyasi. Kata obetni dongruok mar chiwo inenoni oyiengore e chiwo ma koni -gi- koni to gi nywako dongruok mar chiro to oyiengore emedo ohala to gi gero mwandu mang’eny kaka nyalore. Lony ewi thieth ma nya piny (TMK), gi yie mare e dak ma ok oting’ore malo koyiengore e yo makende mar ng’iyo Iwasi mar ngima [chiwono], medo lokore kaka yo motegno ma wuok e Iwasi malokore mar paro. Lony ewi thieth ma nya piny kaka yo mar manyo dak man gi chia e kuonde boma inyalo nene e rang’i mar dok chien mar yiengruok e ngima mar pur, man gi thuolo ok ne tich mar ajuoga kende to gi uso gige thieth e chirni mag boma to gi kuonde gwenge, to kata mar jimbo yuto, ne gwenge koa kuom uso gi thieth, makmana ni kobet tijni lony ewi thieth ma nya piny osebedo gi lokruok e saa to gi e aluora, mokelo pek moko manyien to gi thuolo bende, inene kaka buok ni kawuononi ng’ato nyaloro uso kendo timo ohala e gik mag lony ewi thieth ma nya piny.

Tich mar Ajuoga ineno ka donjo e alap mar menyruok e kind ratiro mag Giken mag Rieko (IPR) to gi yore mag Pogo Ber moyudore (ABS) e ndalogi ma lokruok mar oganda ei alap temo loko chung’ne koa kuom ’mich’ ka biro e ’ngima mara’.
Andika ewi paro midwa fuononi loso ewi chung’ mar juok, mojimbore e ndalogi mar keto ohala ewi thieth, ma nya piny, minyalo tudi kendo inono bathe kod mowuok kuom chenro mag tayo mowuok e loch wagunda to gi loch mabang’ wagunda. Koriwo loko chenro mar telo gi tayo loch e yo ma ndalo cha kaka ne timore e ogendini mitimo nonroni kuomgi. Yor loch mar ruodhi mane yore tendgi ne oriwo lony ewi thieth ma nya piny kendo ne nig i tich mar tayo lony ewi thieth ma nya piny ei ogendini, koriwo yore mag thiro juok to gi yore mag tiyo gi ’mich’ cha e duwo/hinyo oganda. Lokruok mokengegi obedogo, andikani mino e wach, ni okelo dok chien/ng’ukruok e teko ma jo wasikuma gi mise machon mag ogendini mag Luo mar thiro tim madhi nyime ma ok ber ei oganda ma en juok. E yo ma lony ewi thieth ma nya piny to gi juok okalogo piny gi pinje kaka olosie kae nyal o loso yo matiyo e loch moyiedhi kata ma ok oyiedhi kendo keto yore mag lombo telo matiyo e ng’iyo wachgi.
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