Djinn and Tonic
A Study of Health and Healing in Coastal Kenya

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For Juma Muhammed
Thank you for all the arguments and the experiences that I could never have understood without you.

Thank you to the entire Shirazi village for taking me in as a family member, especially to my host grandfather, Babu, for opening the door to his extensive family network of waganga [traditional healers]. Thank you to my translators, Juma and Mwanakame. Thank you to Donna Pido, Jamal Omar, and Odoch Pido, for preparing me for my study in Kenya.

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Chapter 1

Introduction

When I left for Kenya in August 2009, my 23-year-old sister, Erin, had been sick for nearly two years. She had inexplicable cycles of nausea and vomiting, and though we had repeatedly seen the best doctors in the Washington, DC area, we were unable to find a cause or any source of treatment. Over and over again my family and I watched the doctors make tentative suggestions of diagnoses. None of the tests were positive and though we tried many different treatment plans for potential illnesses, nothing provided her with any relief.

As I watched my homebound sister and my parents who put their lives on hold to care for her, I found myself shocked by the gaping holes in Western medicine. My faith in the practice began to dwindle. Though her illness began as episodes of nausea and vomiting, coming and going without pattern and resulting in 18 hospitalizations, by the time I became settled in Kenya my sister’s illness was no longer cyclical. She was sick every day without the previous periods of health. She was homebound for the entire four months I was studying in Kenya with my parents as her primary caregivers. In Kenya, I spoke about her condition to many of my friends and my host family in the Shirazi village, a coastal town where I stayed for two months. After
consulting a few waganga [local healers, singular: mganga], my host family came to believe that the cause of my sister’s illness could be djinn [spirits, singular: jinni].

My host grandfather, Babu [grandfather], was an mganga himself who focused largely on herbal remedies, but he had an extended network of family members who were spiritual waganga. Together with Babu and my translator, I visited a well-known local mganga, Suleman Rashid Tua. This mganga, like many of the waganga I would later visit, was family. He was my great-great-uncle – my host parents were my age so Suleman was roughly 60 years old. To reach him, we traveled an hour by foot up a large hill behind the Shirazi village to an even more remote area with just a few houses. Upon arrival, Babu explained the situation of my sister’s illness and we laughed when the mganga told me in Kiswahili [the Swahili language] that I was the first mzunguu [white person, plural: wazunguu] whom he had ever treated.

Rashid Tua appeared with two large buckets, each half filled with water. The mganga asked Babu to collect leaves from a nearby tree and fill one bucket with whole leaves and the other with the same leaves crumpled. From his house, the mganga brought a number of glass bottles and put the djinn they held, one appearing as a clear liquid and the other a blue powder, into the second bucket. The mganga asked me to place my hands into the bucket with the blue jinni and in my head and heart to explain all of my troubles and why I had come. Afterwards, he told us that we had been transported to America where my sister was sick.

Rashid Tua faced in the direction of America and placed another jinni, also in the powder form, on his outstretched hand. With his other hand, he moved the jinni
back and forth as he lightly dabbed his pointer finger over the front and back of his outstretched hand, reciting incantations and occasionally blowing the powder into the wind. He explained that he was sending the *djinn* to America to take care of my sister. He then did the same procedure with powder from a large horn, repeating my sister’s name as well as my mother’s, and then repeated the process with a different blue-powdered *jinni*. The *mganga* told me to place my hands back in the same blue bucket and slowly wash my arms up to my elbows in the blue water. He then asked me to call my father in America on my cell phone to ask how my sister was doing. I found it difficult to explain to my family that I was calling them for just a brief discussion and could not pause to catch up. They knew something of the ceremony in which I was participating, accepting it as my attempt at a full immersion into Kenyan culture. While I was away, my mother liked to joke that I would come back a witch doctor.

When this part of the ceremony was over, Rashid Tua looked through his large *Falak* [an Arabic book commonly used in Swahili ritual]. *Falak* uses astrology to determine the best dates for events by presenting relationships between days of the week and different *djinn*. It can also be used for producing charms.¹ Rashid Tua explained that my sister’s illness was based in her stomach. According to *Falak*, there was a wound in her back near the backbone, which then traveled up in her body to cause the nausea and vomiting. He told me she would soon become healthy because of these healings.

When I later asked him questions about *Falak*, he explained that it used verses from the Qur’an to determine whether or not he would be able to treat the patient. He

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described how the day of the week, date, and the time of visit were all very important in determining whether it was plausible to treat. He went through each of the days of the week and explained that Saturday is a bad day to be treated but Thursday is the best day, and the closer to Thursday the better.

When we returned to the healing, the mganga took the leaves from one of the original buckets and explained that he was going to send them to my sister in America. He threw the liquid jinni from the bucket towards the West and asked Babu, my translator, and me to repeat my sister’s name out loud. He asked us to aid him because he had trouble pronouncing her name, Erin, while he recited incantations in Arabic, Kiswahili, and local tribal languages. He dipped his hands in the bucket containing the blue-powdered jinni and threw the water to the West as before, and then repeated the process two more times. He explained that we would need to return with udi, uvumba, and ubani [Indian incense] and marashi jabal [perfume]. He explained that these items were a small reward for the djinn to calm them and gave me explicit instructions on the brand and size of the requested items. He told me that once my sister was healed, she would need to come to Kenya to finish her treatment. I told him that she would, insha’Allah [God willing]. He instructed me to again call home the following day to check for any health updates.

When I returned a week later with the requested items, the mganga again presented the two large buckets and asked Babu to gather more leaves. He held the leaves and threw the water again in the direction of America and repeated my sister’s name over and over. He took the blue-powdered jinni, again dabbing his pointer finger back and forth over his outstretched hand and blowing it to the West. He then
lit one of the incense and again requested that I call home to see whether there had been a change in my sister’s health. He then began to tease Babu, his nephew, because he wanted to train him in the craft of working with spirits but Babu said he was too afraid. They argued about keeping the job in the family and in the end the mganga prevailed.

I later asked Babu and other herbalists about what made them so afraid of working with the djinn. They told me that these spirits were very powerful and could cause great harm as well as good, but also that working with djinn in such a way was considered shirk [associating the powers of Allah with another being], and thus went against their Islamic faith. Muslims believe that only Allah has superhuman powers and should be worshipped, and thus many Swahili maintain that developing these relationships with djinn goes against God’s wishes.² Per the mganga’s request, Babu took the leaves and threw the water towards the West, begging the djinn to help my sister, even if she were in a distant location such as a cave. He explained that we would use the other incense once she became healthy. With that, the healing ended.

This healing took place in November of 2009, and by March 2010 my sister had completely recovered. The allopathic medical physicians diagnosed her with a slow digestive system and put her on a regimen of diet and daily laxatives. My sister believes that this healing was a joke, but I question whether there was any correlation to her recovery. I found it difficult to accept the allopathic view of what I experienced, the idea that the Swahili people believed so strongly in what was considered hocus-pocus. When a friend returned to the Kenyan coast this past

summer, I sent her to deliver payment of a goat to the *mganga*. This goat had been our decided fee upon my sister’s health. Fortunately, Rashid Tua still remembered the only *mzunguu* who had ever come to him for help.

**Back to the Beginning**

My time studying abroad in Kenya lasted four months. During the first two months, I lived in Nairobi and studied public health and *Kiswahili* with 22 other American and Asian students with the School of International Training: Development, Health, and Society program. In late September my group of students traveled to the coast of Kenya to stay in the Swahili village of Shirazi for just eight days. *Kiswahili* is the *lingua franca* [a language that connects a large region despite multiple tribal languages] of East Africa but Swahili also denotes that name of a specific tribe with a rich history on the coast. We were the first group of *wazunguu* the Shirazi people had ever spoken with, though American tourists who stayed at a nearby beach resort occasionally toured through the village. The people of Shirazi lived a two-hour bus ride from the nearest city and though they had no electricity or running water, many people carried around cell phones that they occasionally charged by car battery.

I had become interested in ideas of health and traditional medicine primarily because of my sister’s illness. I had been experiencing the limitations of allopathic medical knowledge as my family struggled with my sister’s undiagnosed illness, so

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3 The word Swahili denotes three different entities: a language, a culture, and a specific tribe. Throughout this study I will use *Kiswahili* to discuss the language, as the prefix ki- denotes a language in *Kiswahili*. I will use the term Swahili to signify the tribe and culture, which is distinct to the coast of Kenya, Tanzania, and northern Mozambique. The word Swahili originates in the Arabic word *Sawahlil* [those who reside on the coast].
when we initially visited Shirazi in September I joined a group of students in completing a weeklong research project on traditional medicine. Using the few resources, limited time period (eight days), and our very broken Kiswahili, we set out to get a most basic understanding of traditional medicine in the Shirazi village. During my stay I lived with a host family: my 18-year-old mama (younger than I was), my 22-year-old baba [father], their 2-year-old daughter, and my host grandmother, all of who took me in as a family member. After my initial eight-day stay and preliminary study of Swahili medicine, my interest in the subject blossomed.

I decided to return to Shirazi in November for my month long independent study project while I completed the fieldwork discussed in subsequent chapters. Prior to completing this field research, I had very little background other than general health knowledge of Kenya and some Kiswahili. I was a Neuroscience major at Wesleyan and had yet to begin my coursework in the Science in Society Program, so I also had very little theoretical background for this research. My study abroad program provided me with a field study seminar and an advisor but I also had no real background for field research. At the time, I conceived of my project as a chance to return to the village I had fallen in love with as well as an opportunity to evaluate and compare the types of medical knowledge and resources available to the people of Shirazi. I was interested in health-seeking behavior and determining extent of belief in this concept of spiritual Swahili medicine.

In November, I returned to Shirazi with four other study-abroad students, each of us having a different focus for our studies. Through my school’s contacts in the village, I was connected with a young woman who would be my translator. She had
recently graduated from high school and was looking for work. During my initial survey, I traveled door-to-door in the village asking a formalized set of questions about different diseases and symptom groups, including malaria, flu, fainting, and diarrhea (see survey questions in Appendix II). In each of my survey interviews, I asked about the cause and treatment course for the illnesses. These particular diseases and symptom groups were chosen because they are either those most commonly treated by the nearby Bodo clinic or by traditional medicine. I also gathered basic ethnographic information, such as age, number of children, and education level (see Appendix III for results), as well as information about their usage of traditional medicine (either at-home or with a local healer) and what they thought was the most prominent health problem in Shirazi.

While nearly all Shirazi villagers speak *Kiswahili*, the national language, many of the villager’s primary language were the local *Kifundi* or *Kidigo*. Because of this language barrier, I asked the questions myself in *Kiswahili* and tried to understand the survey responses in *Kiswahili*. When I could not comprehend the villager’s responses, my translator stepped in. I transcribed these interviews by hand.  

Through this initial survey, I interviewed 80 adults in 55 formal individual interviews and 10 formal group interviews. These interviews were formal because I used a standard set of questions for each meeting. Of the estimated 149 households in Shirazi, I was able to interview more than half. Because the village is split into seven

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4 Multiple anthropologists have suggested that people tend to be skeptical about interviewers, particularly when they are transcribing responses in a formal manner. One PhD anthropologist attributed skepticism to the British colonial government, which frequently performs surveys. This generated mistrust of the government. Another suggested that because I came in to do research without a clear alternative motive, I might be mistrusted.
subsections, I sought to interview a similar percentage in each region, thereby receiving a representative sample of the village.

I performed these interviews during the day because of taboos associated with being a woman out at night in a Muslim village. In Shirazi, most men worked during the day while the women stayed home. Consequently 79% of my survey participants were female and only 21% were male. My participants had on average 3.5 children and had gone to school through the American equivalent of fifth grade. According to another study abroad student who also performed her research in the village, the average household income of Shirazi was less than one US dollar per day. In addition to this formal survey, I also had countless informal interviews with village residents during my stay regarding traditional medicine in the area.

After the completion of this initial survey portion of the study, I moved on to interviewing Traditional Medicine Practitioners (TMPs), whom I met primarily through my host family. Because the majority of these practitioners were men, I used a male translator who spoke flawless English and also became a close friend during my stay. During this second portion of my field research, I spoke with 13 TMPs in 17 informal interviews. During these meetings, I took general notes as they were concept translations and not verbatim. I spoke with every TMP in Shirazi and many of the TMPs from surrounding villages, with whom the Shirazi people frequented. We discussed disease causation and treatment, with a particular focus on the spiritual aspect of Swahili healing. In addition to these interviews, I was able to participate in

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and view healing ceremonies of family members and other Shirazi villagers, including the one described at the beginning of this chapter.

Finally, I conducted five informal interviews with the doctor and laboratory technician at the nearby Bodo clinic; performed a formal interview with an administrator from Msambweni District Hospital; and interviewed administrators of local facilities such as the Paradise Lost Resort and the local shop, which sold non-prescription allopathic medications. We discussed treatment options and the nature of hospital-going Shirazi villagers, as well as what resources, including treatments and materials, were provided for them. After completing my one-month field research, I wrote an ethnography as my final paper for the semester abroad based on the information from my interviews. Because of a lack of Internet access and time, I was able to do very little supplemental reading.

Since I returned to Wesleyan, I have been working to expand on this initial ethnography through an extensive literature review. I have also taken a number of relevant courses at Wesleyan, including Philosophy of Science and Theorizing Science and Medicine through the Science in Society Program, all of which have broadened my theoretical understanding of science studies. The following chapters are a compilation of my original field research, a literature review completed upon my return to Wesleyan, and guidance from scholars of science studies within the departments of anthropology, sociology, and philosophy. I will discuss traditional concepts of health and healing in rural coastal Kenya and examine the social and political pressures that have shaped it.
Because of my ordering of research – field research followed by a literature review – I encountered numerous limitations and was forced to learn by trial-and-error in the field. For example, I was forced to change my line of questioning to be more direct halfway through my initial survey upon realizing that my “leading” questions were not sparking the kind of candid discussions I had expected. I believe that were I able to return and extend my project, I would be more prepared and have been able to learn more about identity, concepts of the body, and the mother’s medicine in which I had been originally interested.

Definition of Terms

Throughout the study I will use the term Traditional Medicine Practitioner, or TMP, and mganga interchangeably when discussing the Swahili healers. Negative translations of mganga, such as witchdoctor, remain from the colonial period and have carried over into today. Other English translations include “wizard,” “sorcerer,” “witch,” and “witchcraft,” and have become associated with traditional Swahili medicine and healers. In Shirazi, the English translation of mganga is “witchdoctor,” a term which has extremely negative connotations in the English language. This view of uganga [traditional Swahili medicine] as backwards and anti-modern is accepted by many Westerners as well as other Kenyans. This aura of incredulity was evident throughout my study, as people would laugh nervously whenever the topic of the study was discussed and dismiss Swahili medicine as witchcraft because of their preconceived notions of my personal view of witchcraft.

Many TMPs felt it imperative to differentiate between waganga and witchdoctors, though the literal Kiswahili translation is the same and many Kenyans believe their traditional medicine is actually witchcraft.\(^7\) According to one TMP, an mganga cures diseases, while witchdoctors harm people and bewitch others.\(^8\) Wachawi [practitioners of witchcraft, singular: mchawi] can kill you, turn you into a monkey, or spoil your growth because they use evil spirits. They are used to ruin relationships, harm someone who has wronged, and occasionally make you rich. However it is believed that there are no longer wachawi in Shirazi.\(^9\) While Shirazi TMPs discussed a clear difference between waganga and wachawi, this distinction is heavily contested in other parts of the country. For the purpose of this study, I will present these terms as separate entities, with waganga referring to local healers and wachawi denoting those who use magic to harm others.

I will also discuss traditional medicine in terms of the dichotomy of traditional medicine or Swahili medicine in relation to allopathic medicine, rather than using the terms Western medicine, modern medicine, or biomedicine, due to the colonial power implications associated with the opposite of those identifiers. The term modern medicine implies that Swahili medicine is backwards or primitive; Western medicine suggests that these practices only exist in the West; and biomedicine insinuates that the practice is biological and therefore more connected with the physiological than alternate practices. Even the term allopathic medicine presents difficulties because it is classically defined as the other of traditional medicine.

\(^7\) This is particularly true when speaking to a Western interviewer. This likely would have been different with a local who the interviewee would have assumed to have the same ideas.  
\(^8\) Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 17 November 2009.  
\(^9\) Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 25 November 2009.
Going Forward

The following study will focus on a theoretical expansion of my field research from Kenya. Mark Nichter describes how in sensorial anthropology, "sensations are experienced phenomenologically, interpreted culturally, and responded to socially." I will use this understanding of cultural phenomena as the basis of my work, dissecting and analyzing concepts of health and healing in terms of their social and political influences. As such I will strive to evaluate these understandings of the world in terms of the norms defined by the Swahili people, rather than those evaluative measures used in Western notions of science.

In evaluating understandings of health, one can only legitimately assess an idea within the terms and practices defined by that mode of understanding. We cannot evaluate Swahili medicine by using the Western evaluative techniques of the sterile laboratory. All scientific concepts are contingent on basic assumptions from past scientific discoveries, those pieces of knowledge that Hans-Jörg Rheinberger refers to as “technical objects.” These are the scientific understandings that have become interpreted as baseline facts in the world of science and are thus taken as assumptions. They are the practices and techniques of science, but also the meanings connected with these terms.

We can discuss the example of the search for an Alzheimer’s causing gene to understand the extent of these technical objects in the laboratory. In order to perform this research, a scientist must first take the assumptions tested by researchers before him: a gene is an object in the body that can pass information to offspring; a mutation

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in one of these gene sequences can cause illness; gel electrophoresis identifies the specific nucleotides within a gene; the sterile laboratory is the best environment in which to do the test; and on and on. Any knowledge produced is based on prior understood knowledge. Any method, theory, or instrument relies upon assumptions and standards for science outlined by those sets of norms for understanding science.¹¹

Sometimes these technical objects use the same term but have different meanings in different cultures. An example is that of dirtiness, a Swahili concept of disease to be discussed in Chapter Three. In the allopathic conception of disease, dirtiness implies bacteria, viruses, and other microorganisms that can attack our immune system. To evade this dirtiness, we advocate for sterility in clinical settings and laboratories. However for the Swahili people, dirtiness is both a physical and moral state. It is avoided by ablutions before prayer as well as abstinence from pig, alcohol, and sex before marriage. Though both conceptions of dirtiness are believed to cause illness, the term represents different conceptual practices for different cultures. Without understanding these technical objects, we cannot find what Rheinberger deems “epistemic things,” those new laws that a scientist studies and seeks in the sterile laboratory. We cannot move forward in science.

Joseph Westermeyer describes the difficulties in comparing concepts of healing when he states that TMPs “can function only within his/her own ethnic group, since the shared 'world view' of both healer and patient are usually integral to the

traditional healing process. Donna Haraway discusses a similar notion in terms of feminist science and refers to “situated knowledge.” She fights against the classic conception of objective science and the binary of objective as true and subjective as false, rather suggesting that objectivity is not a singular perspective that any rational individual with the same means and background could determine. She acknowledges that every person has different backgrounds and assumptions, different technical objects through which we see the world. Haraway, like many other science and technology theorists, determined that one cannot watch phenomena from an outside perspective to determine what is true about the world. Rather, we must acknowledge our own biases and background as we can never be separated from how we understand the phenomena and thus what we know it to be.

When discussing scientific research in this way, one can question the authority of the entire method of creating and testing scientific ideas, namely the sterile environment of the laboratory. Classic notions of Western science suggest that this is the only way to gain a completely objective understanding of natural phenomena, but in fact these perspectives, these cultural understandings from which the phenomena arise, are what make this concept of Swahili medicine exist. This entity has been practiced for hundreds of years by generations and generations of Swahili healers. These practices have persisted because they have positive effects on the people who believe in them. It is an entity worth examining that might disappear within the sterile

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laboratory, if we were to remove the specific healer or his or her individual relationships with patients and the community. Thus we must examine it within the technical objects and contexts from which it comes: it arises in nature, is understood culturally and acted upon socially.

In Chapter Two of this study I will discuss the historical and political context surrounding Swahili medicine on the Kenyan coat, providing a discussion of Bantu, Arab, Persia, Indian, British, and post-colonial Kenyan government influences. This will allow us to understand the contested nature of the Swahili identity and provide context for the following two chapters, which will serve as examples of facets of Swahili concepts of medicine discussed in terms of social and political influences. It will serve, along with this introductory chapter, as a way to situate these concepts of health and healing.

In Chapter Three I will discuss concepts of disease through my fieldwork interviews, discussing them in terms of the social and cultural forces that propagate them. Chapter Four will focus on one particular ritual, the Kayamba, which is considered the most important healing practices for spiritual illnesses. Throughout this work, I will examine traditional medicine from rural coastal Kenya, with the Shirazi village as a case study, by evaluating the sociopolitical pressures that have influenced it and the social and cultural responses that maintain it.
Chapter 2

The Great Swahili Coast Melting Pot

On the Swahili Coast of East Africa, a people live balanced between a unique mesh of cultures that provide them varied identities and political tensions. In order to fully understand concepts of health and healing of the Shirazi people, I will examine the history and political background of the people who inhabit the Kenyan coast. Throughout this chapter, I will discuss the influences of these interlocking political forces, as well as the Kenyan government’s approaches to allopathic and traditional medicine from independence to today. I will describe how these political pressures have produced allegiances to other parts of the world and a conflicted worldview that straddles a desire to remain faithful to an Arab and African background and to be Westernized and thus, in the view of the government, modern.

Starting as Bantu tribes from across Africa, the Swahili people were instilled with Islam and Middle Eastern concepts of health as Arab and Persian traders settled in the region. Later, Portuguese and British colonizers brought inequities of race and socioeconomics, an Indian population from other colonies, and a new concept of health expressed in allopathic medicine. After independence, the new Kenyan
government promoted a policy of allopathic healthcare for all citizens but became wrought with corruption as they strove toward a goal of modernization.

African Tribes

The African people of Kenya come from a diverse background of tribes from all over Africa. Nearly every tribe traces their ancestry outside of the national boundaries, with the earliest known ethnic group, the Dakalo people, immigrating over 2,000 years ago. Tribes from three distinct linguistic and ethnic bodies, Cushitic, Nilotic, and Bantu, entered Kenya in time. The nomadic Cushites first came from the north and gave rise to the Somali people, who still populate much of the coast. The migrant Nilotic people, who later came from Ethiopia, descended into populous tribes such as the Luo, Kalenjin, and Maasai. The farming Bantu people later emigrated from West Africa, developing Kiswahili [the Swahili language] and eventually breeding tribes such as the Kikuyu and the Meru. By 700 CE, Bantu speakers had settled the coast and planted seeds for what would become the Swahili people.¹

Middle Eastern Influences: Persians and Omani Arabs

The precise timeline of the Shirazi people of Persia on the East African coast varies according to Arabic histories, Portuguese histories, and the archaeological record. As early as the ninth century CE and as late as the 13th century CE, the Shirazi people reportedly left their home in Persia because they were expelled from their

kingdoms. This claimed history of the Persian settlements around the Shirazi village is substantiated by the stone mosque reportedly dating back to the 11th century, which lies within the land of a vacation resort adjacent to the Shirazi village. Unfortunately, this mosque is not available to the Shirazi villagers, and it is instead maintained as a historical ruin and tourist attraction.

Before this settlement and immersion into coastal culture, Arab traders dispersed along the coast as early as 700 CE. Through these interactions, the Swahili language developed as primarily a combination of Arabic and Bantu dialects. Today, this language acts as the lingua franca [a language that connects a large region despite multiple tribal languages] of East Africa. Arabs originally established the East African trade route to traffic ivory and slaves from the interior of the country. In return for the trading of people, Arabs imported soapstone, glass, and porcelain from China, providing the Bantu dialectic speakers with religion, goods, and written language with which to record their culture.

When the Persians arrived to settle on the coast, Shirazi Persian males married local Bantu females. The offspring inherited the hunger for power and ruling from their Persian fathers and the land from their Bantu mothers. However this version of history is heavily contested. Thomas Spear suggests that these settlers were not in fact from Shirazi, Persia. Instead, he proposes that those who were called Shirazi were

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4 Gordon 39.
6 Chittick 277-282.
actually traders from farther north on the coast, likely African or Afro-Arab traders who called themselves Persians. He also suggests that the Swahili language was not in fact derived directly from these Arab traders, rather from groups of Bantu speaking tribes on the coast that split and developed towns, occasionally adding words from Arabic and the Arabic script. In general Spear ascribes much of the Swahili culture to its Bantu lineage, rather than its Middle Eastern roots.\textsuperscript{8}

Whether or not these original settlers were indeed directly from the Middle East, the coastal Swahili people and specifically the Shirazi villagers with whom I lived and conducted my fieldwork considered themselves direct descendants of these Persians. This is a contested statement in large part because the Shirazi people have dark complexions and thus other Africans do not believe they are descendants of Arabs. On the coast, this lineage provides great pride to the Swahili people, connecting them with their ancestors from the Middle East with whom they often identity more strongly than with the rest of the Kenyan nation.\textsuperscript{9}

These connections with Persian and Arab lineage provide prestige to the Swahili people. They are known for their coastal towns, including Mombasa, Malindi, and Lamu, and are taken to be the developed contrast to those “bush” Kenyans. Bush is a derogatory term for village people, which suggests a backwardness and primitive quality. In contrast, Arabs are seen as sophisticated and civilized, perhaps because of their exotic nature or because of their mercantile history on the coast. This distinction is evident in the Swahili language, where \textit{ustaarabu},

\textsuperscript{8} Spear 300-301.
\textsuperscript{9} McIntosh 9.
literally meaning Arab-like, is translated as “civilized.”

Despite this classification, many of the Swahili people in fact live in farming and fishing villages such as the Shirazi village in which I studied. The Shirazi village lies two hours south of Mombasa, a town reportedly founded and developed by two Shirazi rulers, Shehe Mvita and Queen Mwana Mkisi. Mombasa appears to have been at its height as a slave port around the 15th century. Immigrants and sporadic traders from the Middle East continued to populate and visit the coastal towns, including a visit from famous traveler Ibn Battuta in 1331. As Swahili culture developed into its own entity in Mombasa, immigrants began to arrive from the Swahili north coast of Kenya and the coast of Somalia.

For centuries, the descendants of Persians ruled the city and maintained their control over the religion and culture of Mombasa until the Portuguese arrived in 1498. This began a tumultuous and constant battle for prestige. Interestingly, when Vasco de Gama arrived to encounter malevolence in Mombasa, he moved up the coast to Malindi. There, the Portuguese were treated to a meal and service for their ship, beginning a 200-year friendship between the Malindi port and the European power. Because of Mombasa’s ill-will toward the Portuguese, the European power spent the next 200 years fighting to establish ports and maintain control of Mombasa, though their influence was sporadic and largely relegated to the few forts they were able to establish. For the next few centuries, Mombasa was intermittently controlled

10 McIntosh 53.
11 Spear 293-294.
13 Chittick 292.
15 Chittick 292.
16 Gordon 40.
by the Portuguese, the Sheikhs of Malindi, and occasionally the Imam of Muscat. In 1720 the Omani Arabs officially took control of Mombasa in a fight to maintain Swahili culture\(^{17}\) – after the Mazrui rulers asked for British protection from them in 1827\(^{18}\) – and they ruled until 1837 when the Busaidi Sultans of Zanzibar took control, ruling for the final 60 years before the British colonized the country.\(^{19}\)

In 1887 the Busaidi Sultans of Zanzibar, the ruling party of Mombasa, rented the city to the East Africa Company, the British company that later became the Imperial British East African Company. Less than ten years later, the coast officially came under the British protectorate, though it continued to be ruled by the Sultans of Zanzibar. For the early part of British colonization of Kenya, Arabs and Swahilis continued to control the local government, remaining loosely connected with their soon-to-be British rulers.\(^{20}\)

Upon the time of British arrival, Mombasa was enflamed with fighting amongst Swahili and Arab groups, battling over what had been and would continue to be a point of contention: Arab purity. This ongoing dispute made it impossible to successfully revolt against the British colonizers two years later when the Europeans moved to exert full control over the region. Initially, the British built the Kenya-Uganda railway from Mombasa to the source of the White Nile in Uganda, hoping to gain control over the Nile before the Germans. According to F. Berg, this railway was the death of traditional Swahili society because it changed Mombasa’s economic

\(^{17}\) Berg 47-50.  
\(^{18}\) Gordon 42.  
\(^{19}\) Berg 47-50.  
\(^{20}\) McIntosh 50.
focus to the inland cities and away from the slave trade that so dominated coastal exports.²¹

Arab and Persian settlers integrated into coastal culture over centuries of colonization and contributed concepts of health and personhood to the melting pot nature of the Swahili coast. They created a homogenous Muslim region whereby the teachings and values of the Qur’an were able to disseminate and become Africanized. Power inequities associated with the exotification of those with Arab lineage remain evident in Swahili life today.

**British Colonists**

Much of the Kenyan relationship with allopathic medicine today can be understood in terms of the health priorities and initiatives of the British colonial government. This is primarily because the British built few allopathic medical facilities for the African population. They focused their health initiatives on the European population, providing medical attention only when epidemics arose amongst the Africans. Their sole concern regarding the health of the native population was keeping them barely healthy enough to work.²² Education of the African population also remained a low priority, important only when work for European farms became endangered. Additionally, little energy was directed toward preventive medicine. When epidemiological disasters arose, the local population was resistant to the colonizer’s foreign and unexplained ideas of health and healing. These

²¹ Berg 51-56.
shallow interactions provided opportunity for Kenyans to develop and maintain reliance on traditional medicine.\textsuperscript{23}

At the turn of the 20\textsuperscript{th} century, the first native epidemic of the colonial period, trypanosomiasis (sleeping sickness), arose and the British resorted to their customary epidemiological measures of isolation of those infected. They had yet to establish a sufficient number of hospitals to remove the potentially infected and instead established camps for healthy Africans around Lake Victoria. In classic colonialist strategy, the British ordered an evacuation of these individuals without providing any education or explanation to the Africans. The native population resisted the move, as they were accustomed to treating illness in a more communal manner. To the Africans, illness plagued an entire community, rather than an individual, and thus treatment required the presence of the entire village. The British responded to African opposition of evacuation by killing those they were in fact trying to save, adding to the thousands of people who died from the epidemic.\textsuperscript{24}

In response to the killings, Winston Churchill, the Under Secretary of State for the Colonies, felt the need to step in, stating, “No doubt the clans should have been punished, but 160 have now been killed outright without any further casualties on our side…it looks like butchery.”\textsuperscript{25} Eventually the government relented, stalling the exodus of the healthy Africans to camps. One doctor remarked on the failure of the campaign, “owing to the fact that the majority of the cases which were treated at the

\textsuperscript{25} Minutes by Churchill, 3 February 1908, on Sadler to Elgin, telegram, 31 January 1908, Public Record Office, London (PRO): CO 533/41, cited from Ndege 21.
camp have since died, the natives have no faith in the treatment, and that since they cannot be cured, they would rather die in their own villages than come to the camp to die.”\(^{26}\)

Later epidemics, such as the second trypanosomiasis outbreak in 1901-1902 and the Bubonic Plague upsurge in 1904, highlighted a new isolationist technique developed by the British – racial segregation. The British believed that Africans were somehow closer to nature and therefore more prone to disease, thus the safest measure for the British was remain entirely separate. As these were continual epidemics rather than sporadic outbreaks to which the colonial government was accustomed, this policy of segregation remained for the rest of colonization. When a second Bubonic Plague hit Kisumu in 1908, the British officially split the city into three separate regions – areas for the British, Africans, and Indians.\(^{27}\)

Following the isolation of healthy individuals and the racial segregation around the turn of the century, the colonial government continued to secretly mistreat and propagate mistrust amongst the Africans of their colony. In the 1920s, high death tolls in African hospitals caused the British to questionably dispose of the bodies of African dead because of a scarcity of mortuaries. During World War I the colonial government seized thousands of cattle, citing them as “spontaneous gifts.”\(^{28}\)

George Ndege suggests that it was primarily the differences between allopathic medicine and Swahili medicine that caused mistrust amongst the Africans

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\(^{26}\) J. Pugh, Medical Officer Kanyamkago Sleeping Sickness Camp, to A. D. Milne, Principal Medical Officer, 7 November 1910, enclosure in Girouard to Crewe, 31 May 1911, PRO: CO 533/87, cited from Ndege 24.

\(^{27}\) Ndege 31-39.

at this time. He suggests that colonial allopathic medicine objectified patients, working towards curing diseases through lab results and standardization, as opposed to traditional Swahili practices that worked to cure the entire person and often the community from which they came.\(^{29}\) In 1922, the colonial government decided that the European medical force in Kenya was insufficient and thus should begin to include Africans in their provision of medical care. The National Laboratory in Nairobi began to train Africans in basic laboratory and clinical technician procedures, including preparing blood samples. However, it was not until 1930 that a Kenyan was granted acceptance into a medical degree program at Makarere College in Uganda. Even 15 years later, only 15 African doctors had graduated and were then required to act as an assistant to a European doctor.

The colonial government presented a policy of segregation for hospitals as well as residential areas, requiring separate allopathic medical facilities for the European community, given first priority, then for the Indian community, next in importance, and finally for the African community. However it is important to note that in relation to the rest of Kenya, the Coast Province was appropriated the largest amount of financial medical resources. In 1931, the coast received 0.11 pounds per native person as compared with the next highest province at 0.07 pounds per native in the Rift Valley or the lowest, at 0.001 pounds per native for the Naivasha Province.\(^{30}\) Because of this lack of medical support by the colonial government, Christian missionaries provided much of the allopathic healthcare in the newly created African

\(^{29}\) Ndege 42-43, NPAR 1915-1916, KNA: PC/NZA/1/11 from Ndege 63, 74.

\(^{30}\) Classification of 1931 Expenditure, Medical Department, PRO: CO 533/420 from Ndege 110.
reserves, ghettos used to segregate the Africans by tribes, and these missionaries demanded that Traditional Medicine Practitioners (TMPs) discontinue their work.\(^{31}\)

Before the Great Depression, the British government developed plans to increase healthcare services in the Kenyan reserves, but due to financial constraints was forced to lessen their control over their Kenyan colony. This allowed for the creation of Local Natives Councils (LNCs) in 1925. The LNCs were given small budgets in the reserves to develop infrastructure as they wished. By 1934, LNCs had built 39 dispensaries in Western Kenya, thereby surpassing the number of mission dispensaries at that time.\(^{32}\) These medical facilities largely maintained the British approach of ignoring preventive medicine through outreach and education.\(^{33}\)

The British colonial government recognized that traditional medicine was widespread in Kenya and decided to leave it alone “as long as it did not disturb the peace.” In general, the British were intrigued by these local concepts of disease. After 1930, the colonial government passed *The Witchcraft Act, Cap 67, 1925*, thereby outlawing witchcraft and causing traditional medicine to become a hot-button issue. Despite this new animosity towards local medicine, British officials felt it important to separate between *uchawi* [witchcraft] as “black arts” that was harmful and *uganga* [Swahili medicine], as “white medicine.”\(^{34}\) While today’s Kenyan government sees belief in traditional medicine as an impediment to progress and modernization, the British colonial relationship was more fluid. In the 1930s, allopathic medicine was less fully developed and the British shared this belief in spirits. The British exotified

\(^{32}\) Ndege 104, 117.
\(^{33}\) Ndege 131.
\(^{34}\) Good 37-39.
the Africans in this way, believing they were closer to nature and therefore closer to a
higher power of some kind.\textsuperscript{35} This important distinction of *uchawi* versus *uganga* is
still recognized today, as will be discussed in subsequent chapters.

**Indian Influence**

As was the case in many British colonies, large influxes of Indians came to
settle in the Kenyan colony. Though trading between India and the city of Mombasa
began as early as 1505,\textsuperscript{36} the first group of Indians immigrated in the late 1890s to
build the Kenya-Uganda railway.\textsuperscript{37} During British rule Indians were treated as
second-class citizens, though they always received better treatment than the Africans.
Indians still felt the colonists treated them poorly, particularly in relation to health
matters. An example is the Bubonic Plague epidemic of 1904 and 1908 in Kisumu,
which likely came directly from India since the outbreak began in an Indian Bazaar.
The British responded to the epidemic by segregating the city, treating the Indians
along with the Africans as if they were more prone to disease than the British.\textsuperscript{38}

Though the Indians had initially hoped that Kenya could become the
“America of the Hindu,” British colonists legally forbade Indians from buying land,
thereby forcing them into civil service and trade. Indians established shops
throughout the country, gaining a monopoly on most small and medium sized
businesses.\textsuperscript{39} By World War I, the Indian population of Kenya was twice as large as

\textsuperscript{35} Martin J. Wiener, *An Empire on Trial: Race, Murder, and Justice under British Rule, 1870-1935*,
\textsuperscript{36} Randall L. Pouwels, "The Medieval Foundations of East African Islam," *The International
\textsuperscript{37} Berg 56.
\textsuperscript{38} Ndege 34-39.
\textsuperscript{39} Gordon 49.
the British population.\textsuperscript{40} Upon Kenyan independence in 1963, the British colonists mostly fled from the country, leaving the Indian population behind as a dominant class in Kenyan society.

This division is still evident today, as was exhibited during my stay in Shirazi. A family of Indians had intermarried with a Shirazi family three generations ago. Though most of the family had since left the village for the city of Mombasa, the African grandmother remained. Every \textit{Eid} [the holiday celebrating the end of Ramadan], the Indian grandson brings his family, now seven/eighths Indian, to visit his grandmother in Shirazi. Visiting their great-grandmother who resides in the only stone house in the village that was bought for her by her son, the Indian great-grandchildren complain about the state of the village and their requirement to visit. One of the children asked me with exasperation, “Why don’t they wear shoes?”

The cultural influence of the Indian population is clear on the Swahili coast, providing interesting power dynamics, but it is also visible in materiality. \textit{Chapati} [Indian bread] is a staple all throughout Kenya today. More connected to health and healing, however, is the reliance on perfumes and incense directly from India. As will be discussed in greater detail in subsequent chapters, sweet smelling \textit{udi}, \textit{uvumba}, and \textit{ubani} [incense] are required to call spirits.

\textbf{Kenya since Independence}

When Kenyan gained independence in 1963, the new government inherited a highly fragmented nation. Medical facilities were unevenly distributed, concentrating in urban areas and providing little attention to preventive healthcare. Determined to

\textsuperscript{40} Wiener 209.
make a change, the Kenya African National Union, or KANU, created a welfare state with the ideal of providing free education and healthcare to all citizens. They created the 1966-1970 Development Plan, which worked to promote allopathic methods of healthcare in rural areas and increase the number of dispensaries and trained health workers across the country. They hoped to eradicate illnesses such as tuberculosis, malaria, and leprosy.\(^{41}\)

While the 1960s and '70s provided Kenya with booming economic growth, excessive tribal allegiances caused development to be focused in specific tribal areas. During Jomo Kenyatta’s reign as prime minister and then President, from 1963 to 1978, the Kikuyu leader built social services overwhelmingly in the Kikuyu tribal areas of central Kenya. Later, when Kenyatta died and Daniel arap Moi took over, the new Luo president developed the Luo tribal regions of Western Kenya.\(^{42}\) The new government used social services in an attempt to even racial disparities in allocations left by the British. While successful, the Kenyan government in fact created a new system of inequalities based on tribal inconsistencies.

Throughout the 1970s and '80s, international aid organizations attempted to provide resources where they were lacking. Groups such as The United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), and the World Health Organization (WHO) flocked to the country, continuing to advocate for a strictly allopathic healthcare agenda in the country. For the first time, there was a focus on preventive medicine. By the mid '80s, the Kenyan

\(^{41}\) Ndege 134-138.  
\(^{42}\) Ndege 138-143.
government was funding only 60% of the country’s medical expenditures, with religious, private, and international organizations providing the rest.\textsuperscript{43}

At this time, international organizations began to cut their funding for Kenya. The 1984-1988 District Focus for Rural Development plan shifted healthcare development to districts of the country, rather than cities, though money was sparse. Distribution facilities were only located in Nairobi and corruption quickly became a serious problem in the city. Dispensaries were continually lacking in medications as they disappeared out of the Central Medical Stores. By 1986, Kenya was forced to abandon the welfare state and struggle with the problems and biases it was developing.\textsuperscript{44}

Kenya Today

Most of the official Kenyan health initiatives today revolve around the United Nation’s Millennium Development Goals, an international initiative that strives to meet concrete criteria of poverty relief. By 2015, every country is expected to reduce infant and maternal mortality and combat deadly diseases such as HIV/AIDS, malaria, and tuberculosis along with other non-health related goals.\textsuperscript{45} One method of meeting these goals is through the Community Health Worker (CHW) program, where members from individual communities are trained to perform basic primary care and education outreach. Ideally, the Kenyan government would distribute one

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\textsuperscript{43} Ndege 139.
\textsuperscript{44} Ndege 143-145.
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CHW for every 20 households, empowering communities and spreading the knowledge and resources of allopathic medicine to even the most rural areas.\textsuperscript{46}

While the Kenyan government promotes extensive healthcare initiatives, many are ineffective due to issues of access in rural environments, resource depletion, and corruption. One example is the National Health Sector Strategic Plan of Kenya, 2005-2010, which aimed to immunize more Kenyan children as part of the Millennium Development Goals.\textsuperscript{47} While improvements have been made, the government has only managed to increase their immunization by 2%, from 73% of one-year-olds in 2006 to 75% in 2009.\textsuperscript{48} Additionally, there remains only one mental health hospital in the entire country, likely due to stigma and general attribution of mental instability to witchcraft and spirits, as will be described in subsequent chapters. In 2002, 47 psychiatrists resided in the country, half of them localized in Nairobi. The rest of the country must share only 25 psychiatric physicians.\textsuperscript{49}

As in any developing country, the government has a great interest in producing a healthy and well-informed population because a happy and healthy population is productive and helps Kenya to compete in the world economy. According to the WHO, only 39% of Kenyans use contraceptives and only 42% have given birth attended by a skilled health professional. This 42% is 5% lower than the

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African average. There also remains a discrepancy in health care between urban and rural areas. Only 35% of rural women give birth with a professional, as opposed to 72% of the urban population. This contributes to a shocking mortality rate for children under the age of five, with 117 deaths per 1000 live births in rural areas versus. the 94 in urban areas.\textsuperscript{50}

There is some allopathically based medical infrastructure in the Shirazi region. The study abroad program that originally brought me to the village, the School of International Training, along with other funders recently completed and began to use the Bodo clinic. Located a 40-minute walk from Shirazi, the Bodo clinic presents a unique entrée into the world of allopathic medicine for Shirazi and Bodo, despite the barriers for Shirazi villagers. An influx of patients from many surrounding villages and the small staff cause long lines at the clinic. Distance, resources, and outpatient-only treatment are also obstacles. For in-patient treatment villagers can travel to the nearest hospital, Msambweni District Hospital. However the hospital is only an option for serious issues because it is expensive to access, requiring two separate busses to reach. The access issues with both allopathic medical facilities in the Shirazi area likely contribute to a prevalence of traditional medicine.

The doctors at the Bodo clinic state that one of their primary difficulties in treating the population is faith in alternative health modules such as \textit{uganga}. They claim it causes patients to arrive at the clinic very late and less healthy than they would have been if they had come immediately to the clinic.\textsuperscript{51} Nearly 90% of my informants told me that they have used traditional medicine at some point in their

\textsuperscript{50} World Health Organization, Kenya: Health Profile, 13 August 2010.
\textsuperscript{51} Asha Mwanzi, Personal Interview with Bodo Clinic Physician, 24 September 2009.
lives, and 82% said that they had visited an *mganga*. Although allopathic medicine and Swahili traditional medicine have intersected extensively, as will be discussed in more detail in subsequent chapters, there remain diseases that Swahilis believe allopathic medicine is incapable of treating.\(^52\)

One traditional healer explained to me that traditional Swahili medicine is often chosen over allopathic medicine because it is believed to have fewer side effects and is usually noninvasive and “natural.” Additionally, it is believed to be more holistic in nature, examining the social and culture aspects of the disease, rather than simply analyzing the symptoms to determine causation. Traditional medicine can also examine spiritual aspects of an illness, while allopathic medicine ignores any spiritual concept. Herbal remedies, in particular, are seen as helping the body heal itself, rather than the medication healing the body.\(^53\) Many also consider allopathic medicine to be wrought with inadequacies, such as the example of HIV/AIDS, for which allopathic medicine has yet to find a cure. One TMP explained that he was able to cure AIDS through herbal remedies by using the root of a particular plant, but only if the patient has recently become infected and the disease has not yet spread to the liver.\(^54\) Traditional medicine is also generally very cheap and easily accessible, as most rural villages have numerous TMPs in residence.

Despite ample popular support, traditional medicine remains unstandardized and unregulated. Many herbal remedies have not been tested in clinical trials and thus dosages vary between herbalists. These remedies tend to take much longer to be

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\(^{52}\) Susan Beckerleg, “Swahili Medicine and Healers: The Galenic-Islamic Heritage.”


\(^{54}\) Juma Ali, Personal Interview with Shirazi TMP, 13 November 2009.
effective because they are noninvasive and unconcentrated.\textsuperscript{55} It is also very difficult to regulate traditional treatments because of their popularity in remote rural regions. However, there have been numerous attempts within East Africa to standardize some of these herbal remedies.

One such attempt is Rukararwe in Uganda, a Nongovernmental Organization established in 1986 to uplift the standard of rural people. Other projects include an orphanage and farming, but its main objective is to work with TMPs in determining proper dosages of herbal remedies, collecting information from the communities, processing and packaging treatments, and teaching TMPs to continue herbalism in a sustainable manner. They work with stem cutting, root cutting, and aerating in order to quickly grow new plants for medicine using a human-grown forest and greenhouse. They teach TMPs to harvest these herbs sustainably, as many plants used for treatments are rare or endangered.\textsuperscript{56}

Today, the Kenyan government’s relationship with TMPs is tenuous and varies from year to year. For example, in 2002, the government passed the Traditional Medicine Act, which allows herbalists to practice and distribute medicine in standard allopathic facilities. This law has since been stricken due to allopathic medical practitioner outrage. One physician at the time of the law’s passing publically asked, “Are we moving forward or backwards?”\textsuperscript{57} In the past, the local Msambweni District

\textsuperscript{55} Dahodwala 11, 28. It should be noted that Dahodwala focused his Independent Study Project on herbal traditional medicine, and thus does not consider spiritual and other forms.


Hospital even developed a program to train traditional birthing assistants. The service has since been discontinued.\textsuperscript{58}

The Kenyan government provides a basic process of registration for TMPs. However, registration passes through the Ministry of Culture, rather than the Ministry of Health Services or the Ministry of Public Health and Sanitation. The government’s Pharmacy and Poisons Board need not analyze any medicinal plants. This cultural designation of traditional medicine exemplifies the relationship between the Kenyan government and traditional medicine – it is recognized as a system that persists despite the belief that it is a backwards practice. In most cities, for example, it is largely believed that TMPs are fraudulent magicians who work only to gain a profit.\textsuperscript{59}

To become a registered TMP with the Ministry of Culture, one must fill out a number of forms, receive approval from the local authority and provide five herbal remedies to the Kenyan Medical Research Institute (KEMRI) for verification of nontoxicity. This certification applies only to herbalists and thus entirely excludes those who are primarily spiritual \textit{waganga}.\textsuperscript{60} This separation between herbalist and spiritualist TMPs suggests a greater validity granted to some TMPs and allows this group to practice medicine without necessarily committing to training.

The certified TMPs I interviewed proudly displayed their certificates and government verification, but nearly half of my TMP informants were not government certified. There are, however, other organizations to which TMPs can subscribe and be members, such as the National Association of Traditional Healers and Practitioners.

\begin{footnotesize}
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\item[58] Msambweni District Hospital Nursing Administrator, Personal Interview, 19 November 2009.
\item[60] Dahodwala 33, 40.
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(NATHEPA), though it is unclear what kind of regulations or benefits a TMP might gain from membership.\textsuperscript{61}

Discussion

Today, the relationship between traditional concepts of healing and allopathic medicine is idiosyncratic. The Nyamwaya Patterns suggest that Africans have four types of interactions between allopathic medicine and traditional medicine:

1. The sequential zig-zag pattern occurs when a patient uses both types of medical care, using both to find the easiest and quickest healing option.
2. The supplementary pattern is an instance where only one type of medical care could possibly be used, such as with a spiritual malady.
3. The competitive pattern occurs when either allopathic options or traditional options are taken to be valuable and the patient is forced to choose based on monetary and cultural constraints.
4. The final pattern is complementary, where both forms are thought to be needed for treatment.\textsuperscript{62}

Coastal Kenyans could be characterized as using any of these patterns of allopathic and traditional medical use. The complexity of these interactions exists today because of the multiple political forces acting on the society. Traditional Bantu culture promotes use of and belief in spirits. Throughout much of the country, especially in rural areas, mental health issues are attributed to spirits and the primary health care option in these cases is traditional medicine. Though scholars often attribute the unique culture of the coast to its Arab influences, Randall Pouwels and Thomas Spear suggest that East African Islam should be considered less of an

\textsuperscript{61} Dahodwala 33, 40.
extension of Middle Eastern Islam and more as a relative of inland religion and culture. They suggest the culture is more similar to the rest of Kenya.\textsuperscript{63}

It is commonly believed, for example, that former Kenyan President Moi left an evil \textit{jinni} in the State House in Nairobi causing current President Kibaki’s car crash, amongst other accidents.\textsuperscript{64} Similar beliefs exist in other Bantu, Cushitic, and Nilotic cultures. In fact, it has been estimated that as many as 80\% of Africans rely on traditional medicine for their primary care.\textsuperscript{65} Similarly, the WHO suggests that 70\%-80\% of the population in developed countries has used some form of traditional medicine during their lifetime.\textsuperscript{66}

Islamic influences help shape conceptions of personhood and health along the Swahili coast. In Janet McIntosh’s study of the Giriama people, an urban Bantu tribe of the coastal city of Malindi, she notes that both the Giriama and the Swahili people attribute superiority to the Swahili because of their Arab heritage. While both the Swahilis and Giriama believed that spirits can cause both disease and luck, it was understood by both groups that Arab spirits were distinctly more powerful.\textsuperscript{67} While it is required for Muslims to take medication – if they do not it is considered suicide, which is forbidden – there are no specifications on the type of medicine to take.\textsuperscript{68} Islamic conceptions of health have changed over the years and from region to region.

\textsuperscript{63} See Pouwels 407 and Spear 292.
\textsuperscript{64} Michela Wrong, \textit{It’s Our Turn to Eat: The Story of a Kenyan Whistle-Blower} (Great Britain: HarperCollins Publishers, 2009) 34.
\textsuperscript{66} World Health Organization, Traditional Medicine: December 2008.
\textsuperscript{67} McIntosh 155-162.
While the history of Indian settlers has had a great impact on current day power relations in the country, it does little to influence concepts of health in rural areas of the Kenyan coast. Indian culture has crept into Kenyan culture in numerous ways, including the meal staple of *chapati*, a bread dish that has penetrated countless Kenyan kitchens. This cultural exchange also lends to the prevalence of Indian perfumes and incense in Swahili healing rituals, which will be discussed in more detail in Chapter Four. However these Indian goods contribute to what Edith Turner refers to as the “rarity requirement” in ritual. As Turner describes, these expensive instruments for ritual are extremely important in exotifying the process, allowing the ritual to remain sacred and special.\(^{69}\)

Colonial British influences caused contradictory health-related impacts among the African population. While the British heavily emphasized allopathic medicine, the form of health and healing they accepted to be scientific and thus true, they did little to convince the African people of this belief. They provided little allopathic medical infrastructure or personnel for the Africans and where they did, it was solely in the interest of keeping a healthy workforce. Most notably, they provided little education about the healthcare they provided. During epidemics, the British tried to isolate those who were sick, ripping apart the standard communal protocol of Kenyan traditional medicine. The colonial government in fact created a demand for traditional medicine by their inadequate health care system. Despite this, they managed to convey a sense of backwardness in terms of traditional medicine and healers, whom they deemed

witchdoctors. This is a derogatory term that the British attached to traditional healers which remains to this day.

The colonial legacy of conflicting responses to traditional medicine has continued with the Kenyan government post independence. The general policy of the government has been that traditional medicine is backward and unscientific, and was thus placed under the jurisdiction of the Ministry of Culture rather than the Ministry of Health Services or the Ministry of Public Health and Sanitation. Because of an inability to provide constant and sufficient healthcare, the Kenyan people have instead relied on traditional medicine because of its accessibility, convenience, and price.
Chapter 3

Swahili Concepts of Health

For the Swahili people, concepts of disease are informed by many different, often conflicting sources. Local healers describe an understanding entrenched in spirits and curses, while community allopathic medical personnel and grade school education provide complicated biological explanations that offer little clarity or understanding to their intended audiences. During my month long field study in Shirazi, I performed a household survey where I interviewed over half the families in the village about a number of different illnesses and symptom groups, both about their belief of its cause and their health-seeking behavior in response (For survey questions, see Appendix II). Much of the following chapter results from these findings, though I found that responses were heavily weighted toward allopathic medical responses in regards to health-seeking behavior.

My primary informant and close friend, upon looking at my data, suggested that 99% of people had lied to me about their health-seeking behavior. This distrust may have occurred because I was a foreigner, an outsider, a different race, or alternatively because I came with questions without a clear motive other than just to learn. While my friend may have been incorrect, I believe that the villagers’ health-
seeking behavior was likely slanted towards traditional medicine because of the inaccessibility of the local allopathic medical facilities. Local healers were cheap, nearby, and often family members or life-long friends of patients because of the small size of the village. As a result of these difficulties in my survey, I will provide interpretations of the information gained from my household survey combined with results from my series of informal interviews with 13 local healers. For summaries of my survey results, see Appendix III for demographics and Appendix IV for responses on disease causation and health-seeking behavior.

The following chapter will examine traditional Swahili medicine in terms of its social and political pressures. In discussing Indian traditional medicine, Nichter poignantly describes how "sensations are experienced phenomenologically, interpreted culturally, and responded to socially."\(^1\) I will thus explore Swahili concepts of disease using this methodology, focusing on the concepts of cleanliness and purity, *djinn* [Islamic spirits, singular: *jinni*], *uchawi* [witchcraft], and the effects of unbalanced temperatures.

**Cleanliness and Purity**

As in any Muslim society, the moral, social, and cultural values of Islam are entrenched in Swahili life. In the Qur’an, the Prophet Mohammed required his followers to maintain a high standard of cleanliness, specifically in relation to prayer.\(^2\)

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\(^1\) See Mark Nichter, "Coming to Our Senses: Appreciating the Sensorial in Medical Anthropology," *Transcultural Psychiatry* 45.2, 2008: 167.

\(^2\) "O believers, if you rise to prayer, wash your faces and your hands up to the elbows, and wipe your heads and feet to the ankles. If you are impure, purify yourselves…God desires not to impose are hardship upon you but desires to purify you and perfect his face upon you.” From Tarif Khalidi, *The Qur’an: A New Translation* (Deluxe ed. London: Penguin Classics, 2009 84 (5:5-6).
It is understood that both in prayer and regular life, one must keep themselves at the highest form. The Qur’an places an emphasis on God’s love through purity, stating, "God loves those who constantly repent, who constantly cleanse themselves." ³ This emphasis on cleanliness is both physical and moral. For the Swahili people and other Muslims, there is that which is clean, holy, and pure, and that which is unclean and thus unholy and impure. ⁴ In Swahili conceptions of health, these impurities can cause illness.

The Qur’an requires Muslims to maintain a high standard of physical purity, both in terms of bodily cleanliness and dress. Before prayer, Muslims are required to perform ablutions: washing the face, hands up to the elbows, and feet to the ankles in a precise ritual. Even the type of water used for cleansing is specified in the Qur’an. Presenting a clean and holy front, Muslims are required to wear a spotless white robe during the day and fast during the month of Ramadan. Women in particular are required to keep themselves immaculate in the time surrounding their menstruation, after sex, and giving birth. ⁵

Islam also has extensive moral purity requirements as well. Muslims may not engage in sex before marriage or be alone with a member of the opposite sex before these vows. They are forbidden from drinking alcohol or eating pig meat. One of my informants explained that Allah had provided his people with seductions with which to challenge them. They must walk through temptation and choose to follow the life

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³ Khalidi 30 (2:222).
⁵ McIntosh 144.
that Allah has prescribed. Then Allah will love them because they are pure.\textsuperscript{6} Thus Muslims must be clean and pure in order to be holy and close to God, and this proclivity towards cleanliness as an all-powerful mantra was visible in the Swahili concept of disease for fever and diarrhea.

This idea of dirtiness as a concept of illness was heavily supported by my household survey. Nearly half of my study participants suggested that fever is caused by dust (See Appendix IV: Figure 5A). Nearly 70\% of participants cited dirtiness as the cause of diarrhea, stratified as 52\% citing dirty food or water, 6\% citing dirty stomach, and 11\% citing general dirtiness (See Appendix IV: Figure 6A). Additionally, some participants stated that forbidden drugs in Islam, such as cigarettes, opium, and alcohol, were the cause of diseases such as running crazy and chest pain.\textsuperscript{7}

Islam can also provide methods for curing illness. According to my \textit{waganga} [traditional healer, singular: \textit{mganga}] informants, sometimes illnesses related to Islam require Qur’an-based treatments. The \textit{mganga ya kitabu} [literally the healer of the book or of the Qur’an, plural: \textit{waganga wa vitabu}] uses healing verses of the Qur’an in his treatments.\textsuperscript{8} \textit{Waganga wa vitabu} perform similar treatments to other \textit{waganga}, though they often include healing verses of the Qur’an written in an herbal remedy, 

\begin{itemize}
  \item \textsuperscript{6} Anonymous, Personal Interview with Shirazi Resident, 27 November 2009.
  \item \textsuperscript{7} Asha Salim Suleman, Personal Interview with Shirazi Resident, 9 November 2009. Mshenga Isa Mshenga, Personal Interview with Shirazi Resident, 9 November 2009. Masudi Fumbwe, Personal Interview with Shirazi Resident, 13 November 2009.
\end{itemize}
which is then submerged in water and drunken.\(^9\) Though there is only one such healer in the Shirazi area, occasionally the practice of using Qur’anic verses is performed by other local healers, *waganga wa kienyeji* [more generic traditional healers, singular: *mganga ya kienyeji*].

*Djinn – Spirits*

Another kind of illness related to Islam requires either the aid of *waganga wa vitabu* or *waganga wa kienyeji*. *Djinn* [spirits, singular: *jinni*] can be untrustworthy beings that are believed to both cause illness\(^10\) and cure these maladies. Illnesses caused by *djinn* manifest in symptoms related to the allopathic conception of mental illness. This includes “running crazy,” an illness whereby a person runs seemingly for no reason; repeated nightmares; jumbled thoughts and speech; and speaking in other languages.\(^11\) In the following section, I will elaborate on the nature of these specific spirits because though they are a feature of many Islamic societies, the Swahili understanding is idiosyncratic.

In other traditional Islamic cultures, *djinn* are considered more like *uchawi* [witchcraft], general tomfoolery that causes a change of fortune for a person – either bad luck such as losing a job or good luck, like running into a sum of money. What is distinct to the Swahili concept of *djinn* is not that they have the ability to cause harm but that they can develop relationships with humans to heal others. This concept will

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\(^9\) Mwalim Shee Salim Shee, Personal Interview with Barabarani TMP, 19 November 2009.


While few Shirazi residents mentioned spirits as a mode of causation of disease, this was the main topic of causation with the TMPs and much of their treatment revolved around removal or appeasement of these *djinn*. Because of this and interviews with my close friends and family in Shirazi village, I believe that this is a strong causative factor in belief, though for others it seemed to be a source of embarrassment when speaking with me as a female Western interviewer.

\(^11\) Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 17 November 2009.
be discussed in further detail in Chapter Four, but it can be noted that this idea of adorcism, where a relationship is maintained to be used for healing, can be seen in many nearby surrounding Bantu, Nilotic, and Cushitic cultures. Adorcism opposes the classic notion of exorcism, whereby a spirit is completely removed from its host.

According to the Qur’an, Allah created a world with three types of human-like beings: the people of the sky (angels), the people of the clay (humans), and the people of the fire (*djinn*). *Djinn* are like humans in that they possess free will and have male and female genders, although unlike humans they have special powers because they were the first creatures to be created. They live parallel lives to humans, and because they have free will, they exist within the dichotomy of good and bad behavior. A *jinni* can choose to leave humans alone or can meddle with them – positively or negatively. Some *djinn* develop positive relationships with humans, curing people or causing good luck. Others spend their time harassing humans and cause illness.

In *jinni*-related illnesses, belief in these supernatural beings is essential to the potency of the malady. One informant explained, “if you believe in spirits they can disturb you forever but if you do not, they cannot.” This belief in spirits is complicated by the Swahili people’s quest to be “modern” and possibly conflicts with Islam. While Western society suggests that believing in spirits is backwards and

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14 See Khalidi 206-207 (15:26-42).

15 Kingade Mshee, Personal Interview with Shirazi TMP, 24 November 2009.

16 Binti Omari, Personal Interview with Shirazi Resident, 9 November 2009.
uncivilized, Islam suggests that working with spirits is *shirk* [associating the powers of Allah with another being].¹⁷ Though there are discussions of *djinn* in the Qu’ran, the actual descriptions are vague and do not address the power of the spirits. Much of the perceived power of both disease causation and healing come from outside sources and speculation. In particular, some of my *waganga* informants discussed personal religious issues with their practice of trade, namely that they developed relationships with *djinn* for healing.¹⁸ This judgment on the nature of healing relationships was ambiguous, however, and varied from *mganga* to *mganga*.

*Djinn* are most often perceived as causing craziness, what allopathic medicine would consider mental illness. This includes running crazy, talking to oneself, and continuous nightmares. If a person has been “bitten by a spiritual wind,”¹⁹ he or she might speak in a language in which they cannot normally converse because the *jinni* that possesses them is of a different ethnicity.²⁰ There are rare opportunities to see *djinn* in their true form, though their eyes are said to rotate 360 degrees²¹ in such a way that their image would cause insomnia.²²

Though *djinn* cannot usually be seen, their presence can be felt. For example, if a person is walking on a very hot day and they suddenly feel very cold, this is because a *jinni* is nearby.²³ They are commonly known to live in places that humans

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¹⁸ Anonymous, Personal Interview with Shirazi Resident, 17 November 2009.
¹⁹ Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 25 November 2009.
²⁰ Mvoi (Chipeta) 17 November 2009.
²¹ Ngalaa 15 November 2009.
²² Anonymous, Personal Interview with Shirazi resident, 23 November 2009.
²³ Ngalaa 15 November 2009.
do not inhabit, such as oceans, deserts, caves, and Baobab Trees. Additionally, some believe that every human is born with their own *jinni* that watches the person in the womb and stays with them throughout a lifetime. The spirit can choose to either help them or harm their human. These stories of *djinn* are composed from numerous *waganga* and vary from practitioner to practitioner.

When a *jinni* decides to take interest in a person, it usually appears to him or her in dreams. The spirits can be either male or female, and often a male *jinni* will appear in the dream of a female human and seduce her. This also occurs with female *djinn* and male humans. This is the start of a relationship, which can either cause illness if the *jinni* is bad or stay passive if the spirit takes a liking to their human host. If the relationship is positive, the *jinni* can even cause great wealth. If the *jinni* causing illness is a friendly spirit, it must be calmed by sweet smelling incense and *marashi jabal* [perfume] or by being given rings. Verses from the Qur’an may be written on paper and inserted into a bottle with the perfumes and then drunk for seven days. However not all *djinn* are friendly, and there are some dangerous well-known *djinn* that can cause extreme harm. One example is *Nyari*, whose influence can cause muscular deformity in the mouth, neck, and legs.

Though there are conflicting stories of why *djinn* would choose to harm humans, one explanation is that of an ongoing conflict between the human race and the *djinn* race since the beginning of time. *Djinn* are able to see humans but appear invisible, providing them with a sense of superiority, whereas humans believe

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24 Mvoi (Chipeta) 17 November 2009.
25 Mvoi (Chipeta) 25 November 2009.
26 Rumba Lewa Ngalaa, Personal Interview with Barabarani TMP, 15 November 2009.
27 Salim Shee 19 November 2009.
themselves to be superior because Allah made them in the best way.\textsuperscript{29} Another theory is that \textit{djinn} have no blood in their bodies but require it for sustenance. Thus \textit{djinn} must steal from humans,\textsuperscript{30} similar to the Western conception of vampires. An \textit{mganga} can develop a relationship with \textit{djinn} for healing, and is then considered to own the spirit. This type of symbiotic relationship will be discussed in more detail in the following chapter.

One illness commonly associated with \textit{djinn} is \textit{kupungua akili} [running crazy], a disease for which a TMP visit is required. Although the majority of those interviewed stated that the cause of running crazy was either malaria (32\%) or unknown (42\%), \textit{waganga} stated with confidence that it is an illness of \textit{djinn}. According to one \textit{mganga}, running crazy is caused by the \textit{jinni} bringing the person closer to it so that the person’s blood can be stolen.\textsuperscript{31} This belief was confirmed by the 6\% of participants who stated that running crazy was caused by lack of blood (See Appendix IV: Figure 4A).\textsuperscript{32} A \textit{jinni} is like electricity, and will cause a person to run towards its home, often in the ocean.\textsuperscript{33} The person may also run to the mangrove next the ocean where the \textit{jinni} will drink their blood slowly over a month, if they have not already lost blood during the run.\textsuperscript{34} Without treatment, running crazy will eventually end in death.

\textsuperscript{29} Salim Shee 19 November 2009.
\textsuperscript{30} Ngalaa 15 November 2009.
\textsuperscript{31} Ngalaa 15 November 2009.
\textsuperscript{32} Though this is a small percentage of participants, it was confirmed by nearly all interviewed \textit{waganga}. Additionally, one close informant who was a trustworthy friend suggested that this belief in spirits was much higher than I was told in my survey.
\textsuperscript{33} This concept of the \textit{djinn} living in the ocean causes many Shirazi residents to be afraid of the water. Because of this, many young Shirazi residents never learn how to swim.
\textsuperscript{34} Ngalaa 15 November 2009.
It is also possible to have the same illness without running, whereby a person will be visited by a jinni in the middle of the night, scream, and die instantly. The person will be completely white due to the lack of blood. Some waganga believe these symptoms can also be caused by malaria, which requires a combination of allopathic and Swahili medical care. Once the malaria has reached the brain and caused these symptoms of running crazy and jumbled thoughts and speech, the problem is out of the mganga’s hands and the patient must visit an allopathic medical facility.

Because humans do not have the capability of seeing djinn, they can only be viewed during possession ceremonies. This is a form of hierophany, whereby a possessed person is completely taken over and is incapable of remembering the event. This concept of spirit possession is present in many other communities around the world, perhaps most famously in Santeria, a religion of Cuban and West African heritage. The Santerian priests perform a ritual of drumming and dancing ceremony called orisha, which is similar to the Swahili Kayamba ceremony, as will be discussed in detail in Chapter Four.

When a person is truly possessed by a jinni, they are completely taken over by the personality, knowledge, and bodily characteristics of the spirit. One of my informants shared a story of his uncle who could not speak a word of Arabic but when possessed he spoke fluently. He described another story of two old female waganga who visited the house of a patient. When they arrived, the old women

35 Rumba Lewa Ngalaa, Personal Interview with Barabarani TMP, 15 November 2009.
36 Mvoi (Chipeta), 17 November 2009.
37 Majuma Swere, Personal Interview with Shirazi TMP, 21 September 2009.
immediately became possessed by their *djinn* and the spirit causing the illness became very afraid. In fear, the spirit fled the person’s body and flew into the refrigerator of the house. Because the old women were possessed, they were able to pick up the spirit-containing refrigerator and throw it out of the house. These stories and countless others describe the potential relationships between humans and *djinn*.

In order to become a spiritual TMP, one must gain ownership of a *jinni*. Most often, this relationship is established by the *jinni* itself, rather than the healer. One TMP inherited her *jinni* from her mother, who was initially chosen. Her mother was very ill until a *jinni* appeared in the *mganga*’s dreams to inform her of her chosen status. The woman was required to build an *mzimu* [house, physical structure] for the spirit. When her mother eventually died, the *jinni* chose this TMP to continue the healing tradition. The *jinni* has decided who will take over for her, and the chosen daughter has no choice but to inherit the family trade. The *mganga* is currently training this daughter to take over the practice. In general, if a family decides to discontinue working with the *jinni*, the spirit will disturb the family.

Another *mganga* described how he was chosen by a *jinni* to become a healer. After applying for the certificate from the Kenyan Ministry of Culture, he had a dream and woke up the next morning in the middle of the sea. A person without legs or arms appeared to him and said that the man should remove his clothes to save himself, and when he did he found himself at the ocean’s edge. The same person

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39 Malindi Store Owner, Personal Interview, 21 November 2009.
40 Swere 21 September 2009.
appeared again and led the *mganga* to a cave where he found a white goat and white, red, and black clothes. These became his tools for his first treatment ceremonies.\(^{41}\)

In examining the prominence of spirits in concepts of disease, anthropologists have discussed in great depth how spirits have been used both to maintain and transform social order.\(^{42}\) This can be examined from two angles: the level of the entire village and the interpersonal level. On a larger level, I will discuss the belief in spirits in terms of James Smith’s concept of absolutes.\(^{43}\)

According to Smith, government exists in order to provide a moral structure within which its people function. Ideally, the government organizes institutions that maintain and implement the laws developed by the government. For example, when a person commits a crime, ideally he or she will be punished by the police force. Though of course any government is imperfect in the application of these laws, this government structure does exist in most countries. The Kenyan government, however, is known to be highly corrupt and undependable, receiving a rating of 2.1 out of ten on the 2010 Transparency International corruption index, ranking 154\(^{th}\) out of 178 in level of transparency.\(^{44}\) Since Kenyan society has become one largely without government institutional absolutes, religious and spiritual institutions are left to fulfill this need for order.

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\(^{41}\) Ngala 15 November 2009.
\(^{42}\) See Mary Amuyunzu, “Willing the Spirits to Reveal Themselves: Rural Kenyan Mothers' Responsibility to Restore Their Children's Health,” *Medical Anthropology Quarterly* 1998: 496-497. See also Schuetze and Messing.
When a person commits moral fraud in Kenya, organized institutions of the government will not prosecute. Government scandals of corruption consistently line the front of local and international newspapers as money quietly disappears. Police frequently stand at checkpoints along the highway, stopping cars and requiring bribes for passage. In Kenya, a kitu kidogo [literally a “little something,” bribe, plural: vitu vidogo] is perhaps the one absolute, reliable entity implemented by the Kenyan government. You will be swindled. For Kenyans the kitu kidogo is a normal part of life, much like a tip in a restaurant.45

Although this judicial system absolute does not exist, the human need for absolutes prevails. Spirits often take the place of these absolute institutions. They are reliable in their behavior: upon committing adultery or theft djinn will respond with their displeasure. These spirits, though they can be silly and meddlesome, are strict in their moral code and will always provide punishment for moral defamations. Adultery, for example, is commonly believed to cause and exacerbate illness from spiritual forces.46 If one commits a sin, an act against societal assumptions of morality, these omniscient spirits will punish you. Thus this belief in spirits holds the Swahili people to a strict moral code. Smith’s concept of absolutes applies to the village-wide concept of spirits as a method of maintaining individual morality, but it can also act to alter interpersonal relationships. When Christy Schuetze examined the healing ritual amongst the people of Gorogonsa, Mozambique, she described how

women were able to use this concept of spirits to take a dominant role in their household that is classically controlled by men.  

In her ethnography, Schuetze describes a woman who had been sick for some time – she had been experiencing numbness in her arm and infertility of her daughter (note the communal nature of disease – when a daughter is sick, it can be caused by her mother’s spirits). She discovers that two spirits possessed her, both of whom wanted to engage in marriage with the woman. She thus needed to perform a ritual to complete the requested marriage, thereby turning her into a spirit medium. In the described ritual, the spirits possess the patient and harangue the human husband of their new medium, forcing him to apologize in front of the entire town for mistreating her. She then outlines the nature of the future relationship between the human husband and the spirit husbands, where the human husband would be required to follow orders and be understanding if the woman needed to travel without notice or meet with male visitors who come to her for healing.

One could evaluate this event from two very different perspectives. When examining the incident from a *djinn*-positive perspective, a spirit possessed a woman and formed a mutually beneficial relationship. Alternatively, from an allopatic-positive view, a woman took a powerless situation where she was treated poorly by her husband and she changed it in a positive way. In Kenya, there would be no marriage counseling or restraining order for abuse, no higher institution to alter a situation she deemed unfit. By Smith’s understanding, this woman changed her social situation, be it consciously or subconsciously.

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47 Schuetze 33-38.  
**Uchawi - Witchcraft**

Another common concept of Swahili disease causation is that of *uchawi* [witchcraft]. It is a system used to explain accidents in Swahili culture, such as when livestock or people behave strangely and when a child suddenly dies for no apparent reason.\(^{49}\) Abnormal symptoms, such as dizziness or when a baby does not grow, are strong indicators that a patient has been bewitched.\(^{50}\)

Smith describes Kenyan witchcraft in terms of altering social dynamics. He provides an example of a group of female students in Wundanyi, Kenya who claimed to be possessed by a spirit named Muhammed and openly discussed how he sucked their blood. By Smith’s analysis, the women were in fact presenting their grievances regarding their sale into marriage. The girls did not want to be purchased by their husbands for a onetime payment; rather they felt they could earn more through employment. They believed they were devalued because they could earn more than their bride price if allowed to work. Smith is ambiguous regarding his belief in the women’s self-awareness. He does not specify whether he believes the girls were consciously lying about a spirit in order to gain the upper hand in their situation or whether it was an unconscious consequence of their perceived possession. Smith discusses accusations of witchcraft here as a way to take control of a situation where the players are normally disempowered.\(^{51}\)

While *djinn* and *uchawi* could affect a person at any point in their lives, the Swahili are particularly vulnerable to witchcraft and spirits at early childhood and

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\(^{50}\) Mshee 24 November 2009.

\(^{51}\) Smith 102-104, 113.
pregnancy. These time periods also create vulnerability to *jicho baya* [the evil eye], a curse cast by normal villagers who want to cause illness to someone because of jealousy. The important difference between *uchawi* and *jicho baya* here is that *uchawi* requires a practitioner of witchcraft whereas *jicho baya* can result from any villager’s feelings of ill will. Because of the prevalence of these disease-causing entities, protection plays a large role Swahili medicine and nearly every child and pregnant woman in Shirazi participates. One common way to protect a baby from the *jicho baya* is by using charcoal to draw eyebrows and a star on their foreheads. This is done from as young as one or two weeks to nine months.\(^{52}\) These methods prevent children and adults alike from evil spirits. This concept of the evil eye originates in Arab and Persian understandings of illness.\(^{53}\)

The most common form of protection for small children is *hirizi* [an amulet], which is used to safeguard infants and children from *djinn*, *uchawi*, and *jicho baya*. It is usually made of a combination of ingredients, the most important of which is the heart and thus the soul of different animals. The type of animal used is related to the specific goal of *hirizi*, such as weight gain or relief from crying too much.\(^{54}\) There are two main types of *hirizi* for children, *panole* and *ngata*. These varying forms of *hirizi* protect against different kinds of *djinn* that can cause variable symptoms. *Panole* protects children from *djinn* of the land and is made of a small stick with a hole in it. This stick is tied by string around the waist or leg of the child. *Ngata* protects children from *djinn* of the water and is mostly used for children under two months. *Ngata*

\(^{52}\) Asha Mbaruku, Personal Interview with Shirazi Resident, 29 November 2009.  
\(^{54}\) Juma Ali, Personal Interview with Shirazi TMP, 13 November 2009.
consists of a piece of cloth stained with chicken blood that is tied with different leaves and herbs inside. It is most often worn on the arm. Most of these amulets require particular healing verses from the Qur’an, similar to those used during healing rituals.

Although primarily young children wear hirizi, adults can obtain similar jewelry for protection. Adults can either visit TMPs for hirizi, which is made with herbs like those previously described, or they can get treated with hanzima [amulets containing verses from the Qur’an]. The mganga will chose the type of treatment depending on the illness and the type of protection required.

Just as the majority of Shirazi children wear hirizi for protection, most pregnant women similarly participate in rituals to protect themselves from potential dangers, including jicho baya. By one informant’s estimate, every pregnant woman in the community engages in this ceremony and treatment to protect her from djinn. At seven months of pregnancy, after she has received a full checkup at the local allopathic medical facility, a pregnant woman will visit an mganga for this special ceremony. The patient sits in the center of the room and a red chicken is held over her head and shaken seven times. The red color of the chicken symbolizes blood, so it will more thoroughly appease the jinni that could potentially cause complications. The TMP will then make three small bilateral razor cuts on the wrist, elbow, shoulder, clavicle, foot and knee of the pregnant woman. Finally an herbal remedy is

55 Mshee 24 November 2009.
57 Mshee 24 November 2009.
59 Mshee 24 November 2009.
applied to the incisions on the body. This ceremony is considered to be extremely important for pregnant women, but it notably does not protect the unborn child.\textsuperscript{60}

Unbalanced Temperatures

Another theme within Swahili understandings of disease was that of unbalanced temperatures, a distinction related to weather, temperament of a person, and food. It is widely believed among the Swahili people that too much of one of these entities can cause the other. For example, too much cold is likely to cause fever while too much hot can cause flu. This hot/cold interaction can also result from personality. A person with a hot personality, whom is easy to anger or become excited, is more likely to become ill with hot diseases like stomach ulcers. This is different from weather imbalances, as here too much hot personality aggravates hot illnesses. This is a distinction with personality because it cannot change, whereas the weather often becomes unbalanced. There are also hot and cold foods. Honey is a very hot food, and thus can aggravate hot conditions, such as pregnancy. This combination could cause a baby to be aborted. Combining lime juice and honey is dangerous due to the opposite natures of these foods.\textsuperscript{61}

This conceptual dichotomy of hot and cold can result in illness but can also be used to cure applicable diseases. Mtoro bin Mwinyi Bakari, for example, notes that when one gets caught in the rain and begins to shiver (a disease due to too much cold), the problem can be cured by tea and warm blankets (thus treatment uses its opposite, heat). Similarly, cold remedies, such as rubbing cold water on the head, cure

\textsuperscript{60} Ali 13 November 2009. 
\textsuperscript{61} Susan Beckerleg “Medical Pluralism and Islam in Swahili Communities in Kenya.” \textit{Medical Anthropology Quarterly} 8:3, September 1994, 305-306.
hot diseases, such as heat stroke.\(^\text{62}\) This Swahili understanding of health likely comes from medieval Arabic medicine, which in turn originated largely from the Greeks. According to Greek physicians, the body is composed of four humors: yellow bile, black bile, phlegm, and blood. Each humor was classified as either hot or cold and either dry or moist, and any unbalance of these fluids were thought to cause illness.\(^\text{63}\) To be out of equilibrium in any one of these variables is believed to cause illness.

*Homa* [flu] is considered to be both a cause of illness and a symptom of disease. It was cited as the cause of many diseases from my study, including chest pain (16% of participants, see Appendix IV: Figure 3A), running crazy (6% of participants, see Appendix IV: Figure 4A), and malaria (4% of participants, see Appendix IV: Figure 2A). It was also listed by 51% of participants as one of the prevalent illnesses in Shirazi (See Appendix IV: Figure 1). In *Kiswahili* [the Swahili language], the term *homa* has many different possible meanings, including flu symptoms, cold, or malaria. It is commonly associated with sickness that originates from a changing in the winds, specifically when the monsoon switches from South to North near the Kenyan coast. *Homa* is believed to start in the stomach, causing nausea and vomiting, and then either stays in the stomach as a chronic illness or it moves to the head and becomes very serious.\(^\text{64}\)

Though *homa* is a symptom of unbalanced temperatures, many diseases in my household survey were cited as being caused directly by cold. Change of weather or cold was listed as the cause of chest pain (27% of participants, see Appendix IV: Figure 3A), fever (22% of participants, see Appendix IV: Figure 5A), and malaria

\(^{62}\) Bakari *The Customs of the Swahili People* 133-138.  
^{63}\) Pormann and Savage-Smith 43.  
^{64}\) Beckerleg “Medical Pluralism” 304-305.
(4% of participants, see Appendix IV: Figure 2A). It can also cause pains of the legs and hands.\textsuperscript{65} This theory of disequilibrium in the humors proved to be far reaching, even in a warm area so close to the Equator.

Swahili mothers often use this theory of maintaining equilibrium of the humors to gauge their children’s health. Mothers often require their children to defecate and urinate on the ground in front of them only to remove it later. This way, a mother could analyze her children’s stool and urine for inconsistencies to determine imbalances of humors. However the Kenyan government attempted to admonish this method of diagnosis by requiring latrine usage in all households. While this Ministry of Public Health and Sanitation initiative did reach Shirazi in the past 10-15 years, it remains questioned by the people of the village. Today, many mothers still require their young children relieve themselves in a central location for analysis before the mother will later transport the waste to the latrine. During my stay in Shirazi, my host mother used this method to determine how and when my host sister, aged two, was ill.

Discussion

Allopathic medical facilities do in fact exist along the Swahili coast of Kenya, though they are often difficult to access and expensive. Shirazi villagers have access to non-prescription medication at the local store, a clinic/dispensary, and a hospital within an hour’s walk or bus ride. The local shop sells basic commercially packaged non-prescription medications, including painkillers, malaria and cough medication, and topical cream for muscle aches. This allopathic resource provides fairly

\textsuperscript{65} Mwanamisi Jumba, Personal Interview with Shirazi Resident, 9 November 2009.
inexpensive medications, though pills are sold as individual packages and therefore are ineffective for chronic use. A larger variety of non-prescription medications are available at Barabarani, the nearest town located a 30-40 minute walk from Shirazi.

Though the administrators of my study abroad program are currently building an allopathic medical clinic in Shirazi, today the nearest allopathic medical facility is the Bodo clinic, which was opened by my study abroad program three years ago. This clinic, available via a 30-40 minute walk, requires a 100 KSH consultation fee and is staffed by Christian doctor whose worldview often clashes with that of the homogenous Muslim population surrounding the clinic.

For illnesses beyond the Bodo clinic’s capabilities, patients are sent to the Msambweni District Hospital. To access this facility, Shirazi villagers must travel 1.5 hours by foot and bus. The hospital serves as the only hospital for the 300,000-person Msambweni District and holds only 200 beds for inpatients. The hospital treats an average of 30,000 outpatients and 10,000 inpatients per year. Though the government provides initiatives to curb costs and promote affordable healthcare, fees remain high. Consultation with a doctor is free but overnight stay costs 75 KSH. Pregnancies can be a particularly expensive period of life if one receives allopathic care. At Msambweni District Hospital, a natural birth costs 250 KSH, but a cesarean

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66 The local shop sells maramoja, dawanol, action, paradol, hedex, and aspirin as analgesics, malaratab for malaria, chestcof for coughs, and robo for muscular aches. Each individual pill cost five Kenyan Shillings, KSH, or $0.06 at the time of interview. Information from Ali Rashad, Personal Interview with Shirazi shop owner, 13 November 2009.

67 At the time of study, 100 KSH equaled roughly 1.3 US dollars.

68 At the time of study, bus rides to the hospital cost 250 KSH, roughly 3.25 US dollars. Paradise Lost at Shirazi Bay, a neighboring tourist resort, provides free van rides for emergency situations. The resort has been providing these free rides to the hospital since 1998, and is used mostly at night for births, when a woman and a midnight will travel to Msambweni. One woman had even recently delivered her baby in the van. David Oluoch, Personal Interview Guest Relations Executive of Paradise Lost Resort. 13 November 2009.
section costs 2,500 KSH. Each antenatal visit costs 500 KSH. These fees can be unattainable for many Shirazi families where the average family income is less than one US dollar per day, or about 77 KSH. These factors may in fact push many women toward traditional home birth with traditional birthing attendants, whose level of training can vary.

Despite this prevalence of allopathic medical facilities surrounding Shirazi, barriers to belief and understanding persist regarding allopathic conceptions of disease. Though allopathic concepts, such as germ theory, are taught in primary and secondary education many villagers either do not attend schools or do not believe what is taught. When patients become ill with bacterial infections and antibiotics are required for treatment, “they never come for the full five days. It’s usually two, maybe three days.” This is because the symptom relief occurs after the first days of treatment and they do not believe or have not been exposed to the concept of antibiotic resistance. Issues such as lack of resources and misunderstandings about treatment are rampant in the Bodo clinic and could be a factor causing the population to rely on traditional medicine.

In the Bodo clinician’s opinion, the villagers do not believe in pills because they do not cause pain and thus does not appear to be effective. For this reason the

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69 At the time of study, 75 KSH=97 US dollars, 250 KSH=3.25 US dollars, 2,500 KSH=32.47 US dollars, 500 KSH=6.49 US dollars. Msambweni District Hospital Nursing Administrator, 19 November 2009.
71 Kenyans are only required to complete education through primary school (eighth grade), though many Swahilis do not complete even this much. It is interesting to note that education in Kenya is unsurprisingly unevenly distributed. Test scores are lower on the coast, in large part because the exams are in English, though the national language is English and Kiswahili and little of the coastal population is fluent in English.
72 John S. Mwakamusha, Personal Interview with Bodo Clinic Physician, 18 November 2009.
73 Mwakamusha 18 November 2009.
doctor chooses to treat with quinine and penicillin injections for malaria and infections, respectively, although the less painful pill form is available for both treatments.\textsuperscript{74} This further suggests that the allopathic conception of disease is disseminated into the population, though it is not understood or accepted. This possibly results from the idealized image of Western society and modernization, which encourages Western concepts to be accepted blindly without a deeper understanding. This modernization variable both makes these concepts more accessible and limits their applicability.

The relationship between traditional medicine and allopathic medicine is idiosyncratic, and even \textit{waganga} themselves describe a tumultuous relationship regarding health-seeking behavior. Dr. Chipeta, one of my \textit{mganga} informants, suggested that half of Shirazi villagers visit hospitals and other allopathic medical facilities and half visit TMPs. By his measure, these different healthcare modules must work together because all diseases come in one of three forms. There are diseases that must be treated by allopathic medicine, diseases that must be treated by an \textit{mganga}, and those, such as malaria and pneumonia, that require both methods of treatment. A patient may be lucky and go to the hospital first for a hospital-only disease, or more likely may go to the wrong site and need to visit the other kind of medical facility.\textsuperscript{75} A different \textit{mganga} disagreed, stating that a patient should first visit the hospital for any problem, no matter the illness. If allopathic medicine fails, then the patient should visit a TMP for traditional healing.\textsuperscript{76} This variety of answers

\textsuperscript{74} John S. Mwakamusha, Personal Interview with Bodo Clinic Physician, 16 November 2009.
\textsuperscript{75} Mvoi (Chipeta) 17 November 2009.
\textsuperscript{76} Masudi Fumbwe, Personal Interview with Shirazi TMP, 23 November 2009.
from the waganga themselves exemplify the complex idiosyncratic relationship between allopathic medicine and traditional medicine.

While some traditional healers specialize in treating diseases that originate from spiritual sources, others instead focus on allopathic concepts of disease with traditional herbal cures. Many waganga wa kienyeji provide cheaper and more convenient alternatives to allopathic medical care, though they focus around the same conceptual understandings of disease. These doctors treat stomach problems; loss of appetite; and scabies using roots, leaves, and seeds. One such mganga exemplified the complex relationship between TMPs and the concept of traditional medicine when he described how he only does “real medicine,” providing herbal remedies rather than spiritual alternatives.77 This statement epitomizes the complex political and social motivations of Kenyans today who are caught between Western conceptions of what it means to be “modern” and the classic notion of disease on the Swahili coast.

Campaigns by the Ministry of Health and Human Services and have sought to disseminate information about allopathic concepts of disease to the public. This was particularly evident when discussing malaria, a disease that 48% of the surveyed population listed as being one of Shirazi’s most prevalent illnesses (see Appendix IV: Figure 1) and is responsible for 21% of all deaths of children under the age of five in Kenya.78 Though many families could not afford to buy mosquito nets, Msambweni District Hospital has implemented an initiative providing free nets to any patient in the Maternal Child Clinic and adorns every hospital bed with a covering.79 Evidently these information campaigns have been effective, as 83% of the surveyed population

77 Masudi Fumbwe, Personal Interview with Shirazi TMP, 13 November 2009.
79 Msambweni District Hospital Nursing Administrator, Personal Interview, 19 November 2009.
listed mosquitoes as the primary cause of malaria (See Appendix IV: Figure 2A). However, there appears to be some distrust amongst this knowledge. When asked about the cause of malaria, one informant responded with skepticism, “the hospital says it’s mosquitoes,”\textsuperscript{80} indicating that the allopathic understanding of disease is being disseminated but perhaps not entirely digested or believed.

Ole B. Rekdal refers to “invented tradition” in discussing how this form of traditional conceptions of health and healing are not tradition at all; rather they are a combination of many different cultures. He describes how TMPs often travel around Africa, providing perspectives from many different countries and tribes.\textsuperscript{81} During my research I found that many of the Shirazi TMPs were either born in other countries or had gone away to study. It is therefore unsurprising that many of the allopathic conceptions of health have also permeated Swahili culture. This idea of a strict separation of tribes and culture is in fact a byproduct of British colonial rule. Though before colonization tribal boundaries were fluid, colonial powers split countries on new national lines and the British government in particular separated tribes into Native Reserves, thereby creating concrete tribe distinctions.

While these concepts of health paradigms are difficult to compare and evaluate because of their different assumptions, instruments, and methods for evaluation, we can examine the observable symptoms to search for parallels in these worldviews. Thus we can evaluate what allopathic medicine describes as mental health in relation to the Swahili and Islamic traditions because they rely on the same

\textsuperscript{80} Mwanaulu Hamza, Personal Interview with Shirazi Resident, 10 November 2009.
\textsuperscript{81} Ole B. Rekdal, "Cross-Cultural Healing in East African Ethnography," Medical Anthropology Quarterly 13.4 1999, 472.
symptom groups: change in personality, mood, jumbled cognitive function, hallucinations, and more.

One justification for spiritual explanations of what allopathic medicine would deem mental instability is heavy stigma and a lack of resources for mental health. In Kenya today, there is only one mental health hospital in the entire country, located in Nairobi, and there are no plans for expansion. In the National Health Sector Strategic Plan of Kenya from 2005, mental health is by far the lowest fiscal priority on the budget, receiving only 1% of the equivalent funding of reproductive services or HIV/AIDS in the 2005-2006 fiscal year. The Kenyan government has continued to prove that mental health is of the lowest priority, particularly outside of big cities.

Some anthropologists have suggested, however, that the social forms of healing in many African traditional medical practices are just as beneficial as allopathic mental health treatments. The World Mental Health Report, for example, notes, "The few empirically grounded studies are consistent in their findings that folk and shamanic healers are generally effective in alleviating malaise spawned by psychological and social distress." Edwin Fuller Torrey similarly writes, "the evidence regarding the efficacy of therapists in other cultures is instructive. It is almost unanimous in suggesting that witch doctors get about the same therapeutic results as psychiatrists do."

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Swahili concepts of health can be interpreted and analyzed in terms of their social and political influences. Throughout this chapter, I have discussed four main topics in Swahili medicine: cleanliness and purity, spirits, witchcraft, and the effects of unbalanced temperatures. I have discussed local allopathic medical facilities in terms of their influence on the prevalence of traditional Swahili medicine, suggesting that their lack of resources and stigma attached to mental health could be a causative factor in the existing reliance on traditional medicine. These concepts of health directly result from the melting pot culture of the Swahili coast. By analyzing the origins of these paradigms and examining how the social and political factors both create and define responses to these mechanisms of illness, we can begin to understand Swahili concepts of health as a valid worldview.
Chapter 4

The Adorcism of Mwanasita Shee

Much of the following narrative derives from interviews with Bakari Mvoi, a Shirazi-based Traditional Medicine Practitioner (TMP) who came to be my primary healer contact in Shirazi. I will combine these interviews with my personal experiences at a particularly prominent spiritual healing, the Kayamba ritual, which was linguistically and culturally translated by Shirazi villagers Muhammed Masudi and Doa, my host-father and our friend, respectively. Additional information comes from the recollection and video footage of another Wesleyan study abroad student, Mikako Tai.

Bakari Mvoi, known to his patients as Dr. Chipeta, has been an mganga [traditional healer, plural: waganga] for over ten years. He developed his first relationship with a jinni [spirit, plural: djinn] when he inherited it from his mother, a second generation TMP. Decades before, Chipeta’s grandmother had been visited by a jinni in her dreams and developed a mutually beneficial relationship for healing. Her jinni would take possession of her body, speaking through her like a hierophany (a physical demonstration of the spirit world). As a physical manifestation of something that was normally invisible, she was a spiritual medium who could heal
other humans of their own spiritual illnesses.¹ When Chipeta’s mother became too old to see patients, she transferred ownership of her jinni to her son and bestowed her knowledge of herbal remedies and ritual.²

In Swahili tradition, djinn straddle the disease-inducing/healing binary in their ability to possess humans and either cause illness or develop delicate healing relationships with humans. In exchange for gifts such as jewelry, incense, and perfume, as well as the opportunity to possess an external body, djinn can use their ability to fight off other disease-inducing djinn to heal humans of their external symptoms and send away or quell their possessors. Like humans, djinn can choose to be good or evil,³ but possess supernatural powers of intelligence and strength that provide paranormal opportunities to meddle in the human world. When these healing djinn possess the waganga, these “good” djinn can fight with the “evil” djinn that cause illness,⁴ creating a battle of four separate beings: two possessed human shells and two powerful spirits. These duels rarely end with the complete expulsion of any individual entity; rather the spirits are quelled in a quiet but questionable peace and the sick human’s symptoms disappear. At the end of the process, all four players remain present and entangled in complicated relationships defined by de Heusch’s concept of adorcism. Instead removing the spirit from the body as in the classic

¹ For more on hierophanies, see Mary Ann Clark, “Ambiguities in Santeria Possession Trance: Challenges to the Unitary Self,” Arrival Meeting for the American Academy of Religion, Mysticism Group, 2004: 2-3.
² Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 17 November 2009.
³ Kingade Mshee, Personal Interview with Shirazi TMP, 24 November 2009.
⁴ Mvoi (Chipeta) 17 November 2009.
possession ritual of exorcism, a TMP will work to develop a relationship with the spirit that is either neutral or can be used positively for healing.⁵

Because *djinn* can be dangerous and unpredictable, they produce fear throughout the human community. As invisible and thus mysterious beings, the fear of the unknown is their primary weapon. Physical descriptions of these spirits were often vague and varied extensively between TMPs and even more between Shirazi villagers. These spirits primarily cause symptoms associated with the allopathic conception of mental illness. In an extensive ritual such as the *Kayamba*, the most effective ritual for *jinni* adorcism,⁶ these *djinn* are quelled and calmed by gifts and negotiations until they no longer cause harm but instead remain in a commensal relationship. In this post-*Kayamba* partnership, the *jinni* continues to benefit, often in the form of regular gifts of perfume and incense, while the human is largely unaffected.⁷ Chipeta and other *waganga* use the term *miliki* [ownership] to describe the association between *djinn* and humans, though it is truly the *djinn* that own Chipeta. James Smith argues that *djinn* are unpredictable creatures; at any time a *jinni* could decide it wants a larger gift and its human “owners” have no choice but to comply.⁸

A good *jinni* can be used for healing, as Chipeta uses his, but they can also develop other kinds of relationships with humans. A good spirit might aid its human in getting rich or provide it with the intelligence to make technological

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⁶ Mvoi (Chipeta) 17 November 2009.

⁷ Interview with Bakari Hamisi Mvoi (Chipeta), Shirazi TMP. 25 November 2009.

breakthroughs. These spirits are said to be the true genius behind the use of fire and cooking, and even the more modern technological advancements of the Internet.\(^9\) Because *djinn* are invisible, these interpersonal relationships can exist only in dream. One can even mate with their *jinni* in their dreams.\(^10\) However, the results of these hierophanic experiences occur through physical possession of human forms.

At the start of his healing career, Chipeta underwent intensive training common amongst traditional healers who work with *djinn*. To inaugurate him into the world of spiritual healers, his grandmother cut small incisions underneath Chipeta’s eyes and anointed him with herbs that would allow him to see the spirit world.\(^11\) Though *djinn* and humans cohabitate the same physical area and *djinn* can deliberately interact with humans, this relationship is unilateral.\(^12\) Humans are left to be the subject of these interactions, with the exception of this initial ceremony that allows humans to interact with *djinn* on an individual level, rather than purely through a *jinni*’s possession of a human form. In Chipeta’s training, his grandmother’s *jinni* led him through the forest to teach him about different trees and shrubs to use for healing. Since that time, Chipeta has come to own at least five different *djinn*, providing him with extensive power throughout the community both as a healer and as a connection with higher beings. These relationships are represented by physical entities such as calabashes and jeweled rings, which Chipeta wears on a daily basis,\(^13\) exhibiting wealth and power to all who visit him.

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\(^10\) Mvoi (Chipeta) 17 November 2009.  
\(^11\) Mvoi (Chipeta) 17 November 2009.  
\(^12\) Mshee 24 November 2009.  
\(^13\) Mvoi (Chipeta) 17 November 2009.
As a spiritual and political leader in the Shirazi community, Chipeta plays a uniquely powerful role. He is a trusted member of the social and political elite as a TMP and the secretary of the dispensary board for the proposed allopathic facility, a man committed to the health of the Shirazi people. He is one of the few waganga wa kienyeji [literally traditional or indigenous healer, singular: mganga ya kienyeji] in the area who perform the Kayamba, an important ceremony that acts as a collaboration of the spirit and human worlds as well as a community gathering for much of the village. The ritual is named after the drum/rattle that acts as the central component, and so from here on I will use Kayamba to describe the ritual and kayamba to describe the musical instrument around which the ceremony is based.

The Kayamba is the ultimate ceremony for a person possessed by a jinni, as it provides the opportunity to identify the individual spirit, shower it with gifts, and negotiate its quelling.\footnote{Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 24 November 2009.} It is important to again note that this is not a form of exorcism, as often seen in spirit ceremonies, but rather in de Heusch’s concept of adorcism. The spirit will not leave, rather it will negotiate a less harmful relationship. The Kayamba is performed in two parts, the first to identify the specific identity of the spirit and the second to negotiate the terms of its taming. Both components of the ceremony involve calling the possessing spirit.

In the Kayamba ritual discussed below, Mwanasita Shee, a woman who has been haunted for many years by a jinni, comes to have her spirit quelled. She recently gave birth to her third child, and although she has had this spiritual ceremony in the past, she must experience it again. Her past healings have ended old symptoms, but since the birth of her most recent child she has been experiencing dizziness, loss of...
appetite, and the disappearance of her shadow. This absence of her shadow may be the cause of her symptoms.\(^{15}\) She has spent much of the last few years in the local allopathic hospital, battling her illness from many different avenues.\(^{16}\)

In this Kayamba, Mwanasita will complete her treatment and introduce her new child to the jinni. She has come to Dr. Chipeta for this ceremony upon the birth of each new child in order to introduce her jinni to the new family presence and use the doctor’s good djinn for protection.\(^{17}\) This relationship exemplifies a classic relationship between a jinni and its human. To the human counterpart, it is the woman that is in control. Her jinni is an external part of her life that visits to meddle on rare occasion. In reality, the jinni has the upper hand in the power dynamic and finds itself more a part of the family than the recently birthed child of the patient. This new baby is the outsider. This Kayamba should be the completion of her healing process, permanently quelling the jinni that possesses Mwanasita.\(^{18}\)

Dr. Chipeta exhibits a highly specialized manner of healing spiritual illness. First he must convince the spirits on both sides (his spirits and the one afflicting the patient) to appear through gifts of perfume and incense in order to identify the spirit. When they arrive, the spirits take hold of the human players of the ritual in hierophany. When Mwanasita’s jinni arrives, it will possess her body and speak through her.\(^{19}\) In appearance and sound, she is the same vessel, but the personality and even language is that of the jinni. The same occurs with Chipeta. When the spirits

\(^{15}\) Bakari Hamisi Mvoi (Chipeta), Interview with Shirazi TMP via Juma Muhamed, Shirazi Resident, 12 January 2011.

\(^{16}\) Mvoi (Chipeta) 24 November 2009.

\(^{17}\) Muhammed Masudi Fumbwe and Doah, Personal Interview with Shirazi Residents, 22 November 2009.

\(^{18}\) Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 25 November 2009.

\(^{19}\) Mvoi (Chipeta) 24 November 2009.
arrive, they participate in a series of negotiations. Ideally, in the end, Chipeta’s jinni will persuade Mwanasita’s jinni not to cause more harm. Mwanasita and her family will be at peace, though her jinni will not leave her. Christy Schuetze describes how the relationship will continue with the jinni’s connection persisting, dormant.\textsuperscript{20}

The Kayamba occurs in two parts, separated by 36 hours. In the first segment, Chipeta brings the participants – the patient, family, friends, and his apprentices – to the patient’s house. He arrives with his face painted black from charcoal and dressed in combinations of red, black, and white.\textsuperscript{21} Each spirit requires participants to wear its own garb in combinations of these colors, but most often there is a composite of red and white or black and white, symbolizing the duality of the quality of djinn: dangerous yet able to safeguard from other demons.\textsuperscript{22} The participants crowd into the house with family and friends to begin part one of the healing, as Chipeta genially introduces himself to visitors. He weaves through the crowd with ease, comfortably presiding over the ritual like the host of a party, confidently and fluidly. The women sit uncovered,\textsuperscript{23} despite the societal and religious norms requiring Muslim women to cover their hair when outside or in the presence of men. Chipeta and his apprentices wash their hands and faces with herb-infused water as he begins to play on the kayamba.\textsuperscript{24}

The kayamba is the central component to the ceremony, producing a steady and trance-like beat. It is a simple yet elegant rattle drum composed of bound reeds

\textsuperscript{21} Mikako Tai, Personal Interview with SIT Student, 23 November 2009.
\textsuperscript{22} Schuetze 40.
\textsuperscript{23} Tai 23 November 2009.
\textsuperscript{24} Tai 23 November 2009.
surrounding beads or seeds. The musician creates rhythm in combinations of shaking, hitting and scraping. Chipeta and his apprentices rotate through three techniques of the *kayamba*, combinations of which allow for the rise and fall of energy and dancing throughout the course of ritual. *Kuzumira* [the first stage of drumming] consists of shaking the instrument back and forth, creating a frantic rattle sound. *Kutembeza* [the second stage of drumming] incorporates hitting the instrument with thumbs, creating a deeper, trance-like sound. *Kuchanganya* [the final stage of drumming] consists of a combination of shaking and hitting with thumbs, which allows for a slower-paced beat. These three stages are rotated based on the song and specific *jinni* Chipeta wishes to arise through his possession.\(^{25}\) Here, the male apprentices play the *kayamba* while the female apprentices sing and dance. Chipeta also plays and sings, leading the ceremony like an expert, guiding the entire community in tribute to the spirits and their power.\(^{26}\)

Beginning the ceremony, Chipeta plays a song for his *jinni* Mwanamlongo, an ethnically Digo spirit. For Mwanamlongo, he plays “*Zumirani Uganga Vyo Mlongo,*” translated as the first stage of treatment.\(^{27}\) Chipeta sits on a chair above the patient and the female apprentices, who sit on a mat on the floor. The male apprentices stand in the background and begin to play their *kayambas*, slowly covering their heads with the red, black, and white garments of the *djinn*. By the end of this song, all ritual participants are fully covered. Soon, everyone leaves the house as they sing or play *kayambas*, and Chipeta and Mwanasita break into a sprint.\(^{28}\)

\(^{25}\) Mvoi 25 November 2009.
\(^{26}\) Tai 23 November 2009.
\(^{27}\) Mvoi 25 November 2009.
\(^{28}\) Shirazi *Kayamba*, Dir. Mikako Tai, perf. Bakari Hamisi Mvoi (Chipeta), School of International
Running is common practice when in association with spirits, both as a symptom of illness and here, as part of the healing process. An example is *kupungua akili* [running crazy], a common illness caused by *djinn*. My informants described how possessed people would wake in the middle of the night and begin to run, seemingly with intense purpose but with no explanation. These people will often run to the ocean or a desert, where *djinn* are said to live. The *jinni* calls to the possessed person, bringing his prey to him. *Djinn* act similar the Western conception of vampires – bloodless creatures who live off blood of humans. Humans with the running crazy disease often find themselves sprinting towards their doom hiding in the ocean.

In the *Kayamba*, Chipeta and the patient break into a sprint from the house where the ceremony began. With Mwanasita in the lead, friends and family follow the doctor and his patient, running through grassland for twenty minutes and eventually arriving in a muddy swamp. It is here that Mwanasita’s *jinni* resides and may be where the spirit possesses the patient’s shadow. Schuetze explains that this part of the ceremony is essential in the identification of the particular *jinni* that is causing the illness and as a result, determining the types of gifts and negotiations that will be necessary for its quelling. In ceremonies where the patient is too young or too sick to be the leader in this chase, a relative may act as an intermediary. In discussing a similar ceremony of the Duruma people in central Kenya, Mary Amuyunzu notes that

_Triining, 21 November 2009._

29 Suleman Sweri Chabi, Personal Interview with Shirazi Resident, 18 September 2009.
30 Mshee 24 November 2009.
31 Tai 23 November 2009.
32 Mvoi (Chipeta) 12 January 2011.
33 Schuetze 39.
when this occurs, the *jinni* will summon the family member, bringing the relative and the healers to its home for identification.\(^{34}\) As the others wait on the bank, Chipeta and his patient wade into a small lake in the center of the swamp, slowly covering their limbs with the murky water, immersing themselves in the sludge and calling Mwanasita’s spirit to come and possess her.\(^{35}\)

Covered in mud and displayed before friends and family, Mwanasita’s *jinni* takes over.\(^{36}\) She is completely possessed, violently writhing in the muddy water, her *jinni* struggling to take control of her body. Though the woman’s body remains, she is a shell of a being that has become inhabited by her spirit who can speak and act through her. Chipeta negotiates with the spirit, asking him to let the woman and her family be.\(^{37}\) His female apprentices try to comfort the woman, whose spasms appear painful and violent. When the convulsions subside, the whole group returns to the house, running in single file. Mwanasita carries a bag of gifts for the *jinni* while Chipeta and his apprentices carry two chickens for later use.\(^{38}\)

Under a nearby mango tree, surrounded by friends and family, Chipeta again washes the patient with herb-induced water as the apprentices cover her with the black cloth of the recently identified *jinni*. Chipeta dunks the chickens in the herbal water then shakes each chicken’s head at the woman, spraying her with the medicine dripping off each chicken. First Chipeta uses the white chicken and then the black, thereby carefully calling Mwanasita’s *jinni* to take over again. When the spirit arrives,\(^{34}\) See Mary Amuyunzu, “Willing the Spirits to Reveal Themselves: Rural Kenyan Mothers’ Responsibility to Restore Their Children's Health,” *Medical Anthropology Quarterly* 1998: 496-497. Also, interview with Suleman Rashid Tua, Darigube TMP, Group Informal Interview. 18 November 2009.

\(^{35}\) Tai 23 November 2009.

\(^{36}\) Tai 23 November 2009.

\(^{37}\) Masudi Fumbwe and Doah 22 November 2009.

\(^{38}\) Tai 23 November 2009.
Mwanasita’s body writhes in a new calmer shaking. Swaying to the sound of the *kayamba* drum and still covered in mud, the patient dances alongside the apprentices. The doctor covers the patient’s hands and feet with black chalk, briefly resting different household items on her head. Chipeta thereby presents the tools of daily human life, such as baskets and pots, to the *jinni* as dozens of children watch. This act represents the removal of the burden caused by the *jinni* and the absence of Mwanasita’s shadow.\(^{39}\) By this time, the women have covered their heads with the red and black colors of the *djinn*.\(^{40}\)

During this first component of the *Kayamba*, Chipeta has called his own spirits to fight off Mwanasita’s spirit. In the mud, he was able to bring the woman’s *jinni* to the surface in order to have a discussion about the spirit’s past and future relationship with the patient and her family. He is able to convince the spirit to be calm, as is evidenced by the second possession at the return to the house, where the woman’s second loss of control to the spirit takes a more serene and fluid form.\(^{41}\)

The following day, Chipeta gathers an even larger crowd for the second phase of the healing. Chipeta invited all five American students doing research in the village, showing no concern for picture taking or even video cameras. We joined the 60 villagers prepared to watch and partake in the healing, including a large number of children. This large-scale *Kayamba* acts both as entertainment for the village and as an exhibit of the support system provided to the patient and her family. The healing begins around 10 pm and the audience prepares to stay until sunrise. Many of the women in the audience are again uncovered, despite social and religious norms

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\(^{39}\) Mvoi (Chipeta) 12 January 2011.  
\(^{40}\) Tai 23 November 2009.  
\(^{41}\) Mvoi (Chipeta) 24 November 2009.
requiring Muslim women to cover their heads. The ceremony begins inside with only the family and healers able to fit. After a few minutes of singing, kayamba playing, and incense lighting, Chipeta emerges with the patient, 20 family members, and his apprentices from the depths of the hut. Chipeta and his male apprentices, again playing the kayamba, dress in their everyday jeans and t-shirts though the female apprentices are adorned in the red clothing of the djinn.

Chipeta places Mwanasita in the center of the large crowd, seated up on a chair in front of the audience, who are seated on mats on the ground. She is covered in the black cloth of the djinn, creating a brilliant contrast from the surrounding women in red. The encircled women preoccupy themselves with her, fixing her clothing underneath the cover of another cloth, hidden from the eyes of the spectators. Slowly they begin to dance, swaying with their shoulders and writhing hypnotically. They shimmy to the sounds of the kayamba and Chipeta’s singing, serenading them in the moonlight. Chipeta’s female apprentices fuss over the patient in the center of the crowd, covering her with water laced with udi and uvumba [perfumes to attract the djinn]. For an hour Chipeta plays the kayamba and the women sing and dance, sometimes taken control by spirits and falling to the ground, writhing in spasms. As the songs change, so do the different colored cloths that adorn the participants. Each jinni has its own song that calls to it, and every song is different. Going through some 20 songs throughout the course of the night, Chipeta must call many different healing djinn to determine which spirit is best to fight off the patient’s spirit, and thus the disease. These precise negotiations must be perfect in order to properly mediate the possession and the altering of the relationship – from parasitic, where the jinni

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controls and causes harm to the human, to symbiotic – where both parties benefit or more commonly, the spirit benefits and the human is neutral.

Dr. Chipeta works the crowd and the patient to determine which *djinn* are best for the task of negotiating the terms of the new relationship.\textsuperscript{43} The power and energy of the music and therefore the crowd undulates throughout the night. For some time, the ceremony slows. Chipeta and his male apprentices continue to play the *kayamba* but they sit and sing while the women rest, taking an intermission from their hours of dancing. During this period, Mwanasita is covered again in black cloth. Later, as the music picks up, many of the audience members join in the dancing, perpetually moving and shimmying in a trance-like state.

With each change of song and *jinni*, the apprentices and patient change their ritual garb between combinations of red, white, and black cloth. Chipeta’s own *djinn* are sent to Mwanasita, creating a battle between these spirits of good and that of evil.\textsuperscript{44} Each of Chipeta’s songs sends a different *jinni* to try and determine which spirit is best to negotiate the new relationship. Throughout the course of the night, he will present 20 different *djinn* to the patient. During one song, Mwanasita is possessed by as many as four djinns, a Maasai, an Arab, a Digo, and her own evil *djinn*.\textsuperscript{45}

Once Chipeta determines the proper *jinni* to perform the negotiations, he must introduce the members of the patient’s family to her *jinni*. One by one, Mwanasita’s husband and children are presented to the *jinni* under the cover of a cloth held by the

\textsuperscript{43} Mvoi 25 November 2009.
\textsuperscript{44} Mvoi 17 November 2009.
\textsuperscript{45} These are different ethnicities of the spirits, each requiring their own colors and gifts. Mvoi (Chipeta) 25 November 2009.
apprentices. These preliminary introductions are merely a formality – the jinni has been introduced the rest of the family in previous Kayambas and therefore already knows to protect them rather than cause illness. Now the new baby must be introduced to the spirit, thereby truly inducting the child into the family of which the spirit already belongs. At this introduction of the youngest child, the mother’s top is pulled down, and through Mwanasita the jinni breastfeeds the child. This acts to solidify the new baby’s relationship to the jinni, further demonstrating that this child is a member of the family and the jinni will cause no more harm. The baby screams with fear as he is brought to his writhing, possessed mother.

Chipeta and his apprentices play kayamba, sing, and dance all night. The villagers in the audience awake in the morning to find that the ceremony has finished and the woman is cured, at least for now. As of the time of this paper, over a year after the Kayamba ceremony, Mwanasita and her family remain completely healthy. Her jinni has been quelled and is prepared to protect Mwanasita and her entire family, including her new child. Though the baby is a year and a half old, it is only now that he is truly part of the family that includes both blood and spirit relatives.

Despite potential for beneficial relationships with djinn, these spirits are primarily unpredictable and poorly understood. The Qur’an itself provides only minimal detail on the nature of the djinn, so much of the understandings by those who have yet to engage in the relationship rely on speculation. Much of the information in this study comes from the waganga who maintain these relationships, but my lay

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46 Masudi Fumbwe and Doah 22 November 2009.
47 Mvoi (Chipeta) 12 January 2011.
48 Mvoi (Chipeta) 12 January 2011.
49 Mvoi (Chipeta) 25 November 2009.
Informants provided only fragmented details. It is primarily understood that they are wild and unpredictable, difficult to work with, and extremely dangerous.\textsuperscript{50} For lay villagers, interacting with \textit{djinn} is terrifying and thus the fear of the unknown and poorly understood brings the villagers to these ceremonies. They are provided the opportunity to be in close proximity to these mystical and dangerous beings without the fear of engaging, watching the intrepid \textit{waganga} do their work.

Chipeta, a friendly and personable healer, is thus endowed with bravery few villagers possess when he allows himself to be a medium. \textit{Waganga} alone willingly accept the risks of regularly working with \textit{djinn}, subjecting themselves to the spirits’ unpredictable temperament. Sudhir Kakar discusses the importance of the confidence and competence of the spiritual leader, suggesting that any spiritual problem occurring in the community falls on the inadequacies of the spiritual leader. The leader’s validity is based not on his words, but on the beliefs and actions of his people. Kakar references the following quote from Gandhi that compares the nature of a rose to the nature of a leader as evidence for this claim:

\begin{quote}
The rose does not need to write a book or deliver a sermon on the scent it sheds all around, nor on beauty which everyone who has eyes can see. Well, spiritual life is infinitely superior to the beautiful and fragrant rose, and I make bold to say that the moment there is a spiritual expression in life, the surroundings will readily respond…You cannot deal with millions in any other way.\textsuperscript{51}
\end{quote}

\textsuperscript{50} Anonymous, Personal Interview with Shirazi resident, 23 November 2009.
In addition to watching the *Kayamba* like a show, wide-eyed with terror and fascination, Shirazi villagers are able to give emotional support to the patient and her family, further cementing the communal nature of health and disease on the Swahili coast. The ritual acts like group therapy, where watching this physical manifestation of healing provides a sense of security for the audience’s other troubles. For the Swahili people, the communal nature of health make it such that when one villager is ill, the entire village shares the burden. *Kayambas* and other similar rituals offer villagers the opportunity to support their neighbors without any personal financial loss, creating a community of believers in a society where belief in such spiritual beings is contested in the fight for perceived modernity.

Because of Chipeta’s spiritual connection and role in society, it is extremely important that he produces tangible results at the *Kayamba*. Each *Kayamba* is verification of Chipeta’s powers and connection with the spirit world, as well as of the existence of the *djinn* as a way of understanding the world. It is his opportunity to display his integrity and expertise in the craft of spiritual medicine, as well as his knowledge of the appropriate herbs for divining. For Chipeta’s own livelihood, the healer must convince every participant he is the best *mganga* in Shirazi. They must be persuaded that the next time a family member is overtaken by a spiritual ailment they have no choice but to visit Chipeta and pay the extensive fee of *udi*, *uvumba*, *ubani* [incense], and *marashi jabal* [perfume].

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54 Messing 1120.
More powerful than keeping Chipeta’s livelihood or political power intact, each Kayamba validates the worldview of the Shirazi villagers. With each hierophany of spasms and slurred words, it is proven yet again that the spirit world exists and Chipeta holds a unique connection. It proves that they must continue to live a moral life because these impetuous djinn could strike at any moment. The Swahili people are not in control of their destinies; rather they are subject to the will of these invisible and unpredictable spirits. It is confirmation that their spirits are disembodied, as the Qur’an suggests that it is the soul, rather than the physical body, that makes up a person.55 This goes on to confirm their Islamic faith, a tangible example that the teachings are real, Allah is real, and their acts of morality and good faith are justified.

The Kayamba additionally alters interpersonal relationships amongst the villagers. Before the ritual, the patient was plagued with uncontrolled illness and terrors from feisty spirits. Afterwards, he or she comes out empowered. Mwanasita, with each new baby and each new Kayamba, becomes more and more connected with her spirit. After a Kayamba, a patient is afforded a new position within the community. She is no longer a layperson, but instead a medium through which to interact with the spirit world. In nearby Bantu cultures, this ritual acts as training for the patient to become a Traditional Medicine Practitioner his or herself.56

Now that Mwanasita has established this relationship with her spirit, she is afforded the power position in her relationships. At any point, her jinni might demand

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56 Schuetze 40.
perfumes, incense, or tasks to be done by her husband. Though a woman in a patriarchal society, Mwanasita is now afforded the upper hand in her marriage. Her relations have no choice but to follow her orders, as any imprecise move could anger her spirit and cause him to respond in unpredictable ways. This jinni, and thus Mwanasita as a medium through which he speaks and acts, is the head of the household. For example, it is only after he meets the new baby that the child truly becomes a part of its own family.

This idea of spiritual healing as providing group therapy and patient empowerment in relationships are prevalent in other Swahili cultures as well as inland Kenya, where the culture lacks the strong Arab influence. An example is a ritual of the Ndembu people as described by Edith Turner. In her discussion of their ceremonies, she describes a patient neglected by her family, ailed by a hunter’s tooth. For the Ndembu healings, the entire village must speak their “words,” airing their personal social issues to the entire community. The spirit cannot leave and thus the patient cannot be healed until a social equilibrium is reached.\(^{57}\)

A Kayamba is a typical rite of passage as described by Victor Turner in his discussions of liminality and communitas. Turner describes rituals that act as an entryway to an alternative position in society, the liminality, and the camaraderie afforded to the participants afterward, the communitas. During the period of liminality, normal social cues disappear and identity is briefly lost. The participants lose their gender and individuality, all dressing the same.\(^{58}\) In the Kayamba, the


participants don the red, white, and black cloths of the djinn. Chipeta, though a male, dons the cloths as skirts. The women ignore the social and religious ordinance of femalehood and modesty, uncovering their heads even in the presence of men. They take on the identity of the spirits they channel, no longer themselves but rather a shell of a body. They are, as Turner describes, a *tabula rasa* [blank state].

During this period of liminality, the patient and *djinn* learn how to interact with one another. The patient is taught what to expect of this new relationship – how often his or her spirit will require attention and what gifts it requires in order to maintain a mutually-beneficial relationship. The *Kayamba* participants become a communitas, no longer separate entities but one form brought through the same training period. After this *Kayamba*, these individual people go back to their normal social habits of men wearing pants and women covering their heads, but the bond continues and in fact a new position in society has been created. They are a communitas.

This period of liminality provides a unique position for participants, but once the period is complete, an entirely new social order exists. When Mwanasita leaves the *Kayamba*, she is no longer a patient, an invalid. Instead she is a medium, a connection to the spirit world and herself an absolute, evidence of a correct worldview. Chipeta and his apprentices will never truly leave this existence of liminality, always provided their own norms, and it is this *Kayamba* that affords them this marginal position within society, free from social constraints.

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59 Victor Turner 364.
60 Victor Turner 259-260.
For Dr. Chipeta and other waganga wa kienyeji, this type of healing cements their positions as political leaders within the community. These massive ceremonies occur about ten times per year and act as entertainment for the Shirazi villagers. At this particular Kayamba, 60 people came to watch and participate in the all-night ceremony. The rituals occur primarily during the harvest, when villagers have much to sacrifice to the spirits and the Traditional Medicine Practitioner, for the fee is high. The patient’s family must provide both monetary compensation for the mganga and goods for the djinn. The spirits require expensive perfumes and incense that must last the entire night and thus only the wealthiest family can afford the ceremony for their kin.

For Chipeta, these rituals act as the ultimate showing of his power. In front of a large audience, the mganga produces physical and emotional responses by way of his djinn, thereby exhibiting his connection with the spirit world. Causing both exhilaration and fear, these Kayambas allow the villagers to come close to the divine and the absolute, providing Chipeta a position of respect and command within the community. This political leadership role is evidenced by Chipeta’s position as secretary of the dispensary board for the proposed allopathic health clinic in Shirazi.

For the nearby Bodo clinic and Msambweni District Hospital, the nearest allopathic facilities, the Kayamba plays an extremely different role. To their staff, traditional medicine is nothing more than a cultural relic, a holdover from the past. These concepts of disease and healing may have a social and cultural purpose, but that is the full extent of their power. In fact, the doctor at the nearest Bodo clinic is

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62 Mvoi 17 November 2009.
63 Mvoi 17 November 2009.
Christian, so while he believes in the power of spirits to cause illness, he recommends Christian prayer rather than Kayambas for spiritual healing. In taking the Hippocratic Oath, these doctors confirmed their responsibility to the public to aid and nurse them back to health and believe that here the villager’s concepts of medicine and illness stand in their way.64

Because of these contrasting concepts of health and the complexity of health-seeking behaviors of the villagers, patients will frequently arrive at the Bodo clinic extremely sick, having already exhausted their Swahili medical options. The clinician at the Bodo clinic explained how frustrating it was to find that the clinic staff could have helped the patients with their allopathic medical resources if they had come earlier in the disease progression. Similarly, because the villager’s understanding of allopathic health practices and concepts of disease causation is minimal, if they believe it at all, issues arise.65 For example, during my visits at the clinic a teenage boy arrived with a septic wound and was given a capsule to take overnight. When the boy returned the following day, the doctor discovered he had opened up the capsule and distributed the yellow powder across his wound.66

Part of this difficulty in determining dangerous drug interactions with traditional medicine results from the governments lack of regulation of traditional herbal remedies. Thus different healers will use different concentrations of plant extracts. Even when these prescriptions are recorded, herbs have different concentrations and thus different potencies depending on the environment, such as

64 John S. Mwakamusha, Personal Interview with Bodo Clinic Physician, 16 November 2009.
65 Mwakamusha 16 November 2009.
66 Interview with Dr. John S. Mwakamusha, Bodo Clinic Physician. 26 November 2009.
hot wet weather vs. cold dry weather. Allopathic medical practitioners find difficulty in prescribing medication because they cannot know whether the combination of drugs will have a negative interaction with an herbal remedy. Many patients will not even tell their allopathic doctors that they used traditional medicine before visiting for fear that they will be sent away and not treated.

Thus allopathic practitioners may see traditional medicine as an important cultural relic, but usually assume it is a less valid form of healing. They see the body and mind as a distinct dichotomy and as such they separate diseases relating to these parts of a person. This is not true of the Shirazi villagers, who believe that an illness could have biological as well as spiritual and social causes. This difference in worldview is an important separation that makes traditional medicine dangerous for allopathic practitioners.

The Kayamba ritual is widely used throughout the Swahili coast as the ultimate form of healing for spiritual illnesses, providing the opportunity for an mganga to identify the illness-causing spirit and engage in a dialogue with the spirit to manipulate the relationship from parasitic to symbiotic. These traditional forms of healing can be viewed as an important cultural entity, providing villagers with entertainment, verification of their worldview, an opportunity to maintain social equilibrium, and become empowered in society. Through either the djinn-positive perspective or the allopathic-positive perspective, we can understand the Kayamba as being imperative in maintaining the health, social, and cultural balance of the village.

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67 Nyamwaya 25.
68 Nyamwaya 25.
69 Nwamwaya 18-19.
Chapter 5

Moving Forward

During my fieldwork in the Shirazi village of coastal Kenya, I discovered that conceptions of health and healing were complicated and distinct, arising from centuries of political and social circumstances that shape interpersonal as well as village interactions today. I worked to gain insight on concepts of illness, healing, and health-seeking behavior of the Shirazi people through my formal survey of 80 adult individuals, interviews with local Traditional Medicine Practitioners (TMPs) of the spiritual and herbal variety, meetings with local allopathic medical physicians, administrators, and technicians, as well as countless informal discussions with Shirazi villagers.

By understanding the political context of the Swahili coast, we are able to situate the Swahili people in a unique meld of forces that have led to a distinct relationship with health and healing, Islam, and issues of modernity. In discussing these concepts of health in terms of situated knowledge within their own bounds and norms, we are able to define both the development of these ideas and practices and their application as legitimate and valid. We see Swahili medicine in terms of their temporal and spatial nature, resulting from limited existing social and political
institutions. The rituals associated with Swahili medicine exhibit the depth of influence these institutions have on interpersonal relationships in Swahili villages such as Shirazi. We can understand these beliefs and practices as legitimate in terms of the social, political, and historical tensions that shape them.

Swahili Medicine: A Dying Practice?

During my fieldwork, I asked these waganga [local healers, TMPs] how the use of traditional medicine had changed over the years. I wanted to try to determine whether the allopathic resources that were rapidly becoming available and the government agenda of modernization and education were causing a decline in the use of traditional medicine on the coast. Some TMPs explained that their practice had not changed over time; their patients have remained the same since the time of their training. Some TMPs, particularly the older healers, disagreed, suggesting that business had declined over the years. One TMP informant explained that the djinn have become less strong, but also that there has been a change in patient attitude over the years. People are more likely to visit allopathic medical facilities than in the past, and thus the TMP’s patient networks have declined.

The relevant literature supports this claim of decline in traditional medicine in Swahili culture. They suggest that Western and Arab influences, as well as an increase in the influence of traditional Islam, have caused spiritual practices in particular to decline. These cultures have linked possession and spirit worship with

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1 Kingade Mshee, Personal Interview with Shirazi TMP, 24 November 2009.
2 Majuma Swere, Personal Interview with Shirazi TMP, 21 September 2009.
backwardness and unsophistication, causing excessive stigma in places once heavily reliant on the work of waganga. This decline appears to be occurring most notably in the cities along the coasts of Kenya and Tanzania, though spiritual cults were once popular and visible in all Swahili culture. While some attribute this decline to an increase in accessible allopathic alternatives or Westernization, others suggest that djinn simply dislike the modernization; they avoid Western-style buildings, paved roads and crowded areas, and thus are forced to avoid big coastal cities like Mombasa.⁴⁴

Another potential reason for the decline in Swahili medicine is an increase in the influence of conservative Islam, which some believe forbids forming relationships with these spirits. Some believe that ownership of djinn and the use of djinn for healing is shirk [associating Allah’s power with another being].⁵ An mganga ya kitabu [healer of the book, Qur’anic scholar who heals using verses, plural: waganga wa vitabu] agreed, stating, “Religion does not support them because they do things against the will of God.”⁶ However another TMP disagreed, declaring, “It does not concern religion. This is a job and cannot be compared with religion.”⁷

Despite this ambiguous relationship with Islam, many waganga continue to practice. One of the Shirazi TMPs, reputed by some to be the best in the area and frequently visited by customers from around the coast, recently began refusing to practice because of this conflict. It is believed that when a person refuses to practice, despite an established relationship with a jinni, the spirit may respond unfavorably. In

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⁴ Giles 92.
⁵ Mshee 24 November 2009.
⁶ Mwalim Shee Salim Shee, Personal Interview with Barabarani TMP, 19 November 2009.
⁷ Bakari Hamisi Mvoi (Chipeta), Personal Interview with Shirazi TMP, 17 November 2009.
the case of this particular *mganga*, her jinni responds to her unwillingness to use it for healing by forcing her to have irregular muscular spasms. This shows the displeasure of the spirit to all those who come to visit. I was able to see this muscular spasm myself during my stay in Shirazi, though this *mganga* refused to meet with me a second time due in part to her desire to give up the healing profession.

### Regrets and Recommendations

Throughout my thesis writing process, I have been able to understand my experiences in Kenya from an intellectual and informed perspective. I have personally gained a great deal from this weighty endeavor; however were I to undertake a similar study in the future I would approach it very differently. Although I had some basic background in Kenyan history and *Kiswahili* [the Swahili language] at the beginning of my research, but I knew very little about the methodological and theoretical background in which I studied. I strongly believe this study could have been improved had I completed my Science in Society Program coursework and had a comprehensive training in anthropology prior to doing my research. Upon returning from Kenya, I was left to make connections from the research I had, though it was somewhat incomplete in my questioning and evolved throughout the study. I could not return to Kenya to ask new questions or explore new avenues of study. For example, I did not have enough time in my study to ask many preliminary questions that would have helped to shape my survey. I did not have time for mistakes, though I made them, and thus I was forced to change my questions halfway through. As I

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8 Anonymous, Personal Interview with Shirazi Resident, 17 November 2009.
learned how to ask questions in a more socially and culturally conscious way, my questions and answers changed.

Looking back at my fieldwork, I realize that my study could have been greatly improved with more time and education, but also it could have been expanded in a number of ways. I would have liked to perform my survey in other Swahili villages and compare it to coastal urban centers. I would have liked to also study traditional medicine inland, and thus be able to juxtapose concepts of health and healing to other Bantu cultures. I believe this would have given me a better understanding of the effects of Bantu heritage, as well as Islamic and British influences. I also would have liked to return to Shirazi to be trained by the waganga, an opportunity I was offered during my stay, thereby experiencing concepts of health and healing from the inside of the medical profession.

I would have liked to learn more about jicho baya [the evil eye], to determine how this and other forms of uchawi [witchcraft] affected the villagers on a day-to-day basis, rather than just as a concept of illness. Similarly, I would have liked to learn more about mother’s medicine, the type of medical knowledge held by every member of the village for non life-threatening illnesses. Both of these research paths would have required a much longer period of study.

Additionally, I would have liked to further examine the politics surrounding the quest for being “modern” in a developing country. During my research it became clear that this was a heavily contributing factor in my interviews, particularly when my friend and translator told me that 99% of my informants had lied to me. Were I to
have had the time to ask appropriate questions and study the relevant literature, I think this could have been an important addition to my study.

Perhaps most importantly, if I had more time during my field study period I would have been able to become more integrated into Shirazi society. Although I felt comfortable in the village and my home stay family treated me as though I were nearly one of their own, the fact that I was an outsider was obvious and thus had an immeasurable impact on the Shirazi peoples’ responses to my survey questions. For example, the fact that during my household survey such an overwhelming proportion of villagers told me they would visit allopathic medical facilities for nearly every disease and illness set I questioned is very likely untrue because of the high costs of medical care and transportation. This may have been the ideal situation for the villagers, however I do not believe it was the reality. I also would have liked to stay long enough to be able to understand the subtle cultural assumptions that I had not grown up with, such as how to best obtain responses to my questions and how to interact with those I was interviewing. However, for this to happen I would need to live in Shirazi for years.

In addition to expanding on my current study, I would love to have the opportunity to work within my other field of study, neuroscience, in the burgeoning field of neuroanthropology. This newly developing field will provide a unique dimension to cultural understandings – ethnographic studies and other field work will be accompanied by Western scientific practice. This work will be able to remain in

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9 My translator and friend, upon looking through my notebook with survey responses, told me that 99% of my informants had lied to me about their health-seeking behavior. While this may be untrue, it seems very unlikely that the people of Shirazi would travel over an hour away on foot or by bus to receive allopathic treatment when traditional herbal and spiritual remedies were cheap and easily accessible.
the location of study rather than in the sterile laboratory, completing empirically based studies within alternative cultural contexts. Some such past studies have worked to monitor trance and possession experiences using Western neurological imaging technologies such as PET scans and MRIs.\(^\text{10}\)

These methods will also provide a unique common ground with which to study these culturally significant occurrences. Many neuroscientists and psychologists have similarly examined culture in animals in laboratory settings, providing some insight into the evolution of these cultural practices and rituals.\(^\text{11}\) With this new field of neuroanthropology, scientists will be able to put aside their skepticism and try to examine these foreign paradigms through their own practices and methods, which today we are unable to do.


\(\text{\textsuperscript{11} See Lazar et al., 2005; Lutz et al., 2009; Kakigi et al., 2005; and Riba et al., 2006; as discussed in Cambell and Garcia, 2009, 2.}\)
APPENDIX I: DEFINITIONS OF TERMS

Adorcism – a form of spirit interaction whereby the spirit remains in the body after a healing ritual. This opposes the classic notion of exorcism whereby the spirit is removed from the body.¹

Baba – father, refers to my host father who I stayed with during my time in Shirazi; pronounced bah-bah.

Babu – grandfather, refers to my host grandfather who was both a TMP and related to a number of TMPs; pronounced bah-boo.

Chapati – a Kenyan bread staple that originated in India; pronounced chah-pah-tee.

Communitas – the relationships formed after a period of liminality

Djinn (pl) – a spirit from the Qur’an, the same as genie, spirit, sorcerer; singular: jinni; pronounced jinni.

Eid - the holiday celebrating the end of Ramadan, a month long period of fasting; pronounced eed.

Falak - an Arabic astrology book commonly used in Swahili ritual. The book is used to determine the best dates for events based on the Qur’an. The book lists the days of the week and their relation to numbers and different djinn. It can also be used to produce charms; pronounced fah-lock.

Hanzima – similar to hirizi, it is a type of jewelry that contains the words of the Qur’an to protect an adult from djinn, uchawi, or jicho baya; pronounced han-zee-ma.

Hierophany – a manifestation of the invisible in the visible world

Hirizi – a type of amulet that is used to protect children and adults from djinn and jicho baya; pronounced eer-ee-zee.

Homa – depending on the location and dialect of the region can be switched in meaning or also indicate a number of symptoms such as headache, runny nose, fever, general aches, and more. Homa is often associated with malaria, but can also be its own entity. It can be a general term for sickness; pronounced ho-ma.

Hospitali – literally means hospital, but is used to refer to any allopathic medical facility. In the case of Shirazi it refers to both the Msambweni District Hospital and the Bodo Clinic; pronounced hoss-pee-tah-lee.

Insha’Allah – God willing, a common Arabic phrase that often accompanies something that you wish to happen in the future. For example, my sister will come to Kenya to finish her treatment, insha’Allah; pronounced in-shah-ul-lah

Jicho Baya – bad eyes or the evil eye, is considered a strong causative of disease in Shirazi, particularly during vulnerable life periods such as pregnancy and early childhood. It can be caused by people ill wishing on others, or by a deliberate use of uchawi by witchdoctors in a form of bewitching; pronounced jee-koh bah-yah.

Jinni (s) – coastal/Islamic spirit, same as sorcerer, genie, or spirit; plural: djinn; pronounced jin-nee.

Kayamba – both a musical instrument and the ritual in which the rattle is focused. It is both a shaker and a drum that is used in an important healing ceremony with the

same name. It was started in the Kamba community and is used to appease a *jinni* that could potentially cause disease, instead convincing it to work as a protector. Throughout this study, I refer to the rattle as *kayamba* and the ceremony as *Kayamba*; pronounced kah-yahm-bah.

*Kifundi* – the Fundi language, a tribal language from around Shirazi. The Ki- prefix denotes a language. Similarly, *Kiswahili* is the Swahili language; pronounced kee-foon-dee.

*Kipemba* – the Pemba language, a tribal language from around Shirazi. The Ki- prefix denotes a language. Similarly, *Kiswahili* is the Swahili language; pronounced kee-pem-ba.

*Kiswahili* – refers to the language Swahili. The Ki- prefix denotes a language. Similarly, *Kipemba* is the Pemba language; pronounced kee-swah-hee-lee.

*Kitu Kidogo* (s) – bribe, extremely commonplace in Kenya, most notably when interacting with formal government institutions like the police; plural: *vitu vidogo*; pronounced kee-too kee-doh-go.

*Kuchanganya* – the third stage of drumming for each *jinni* called in a *Kayamba*, consists of shaking the instrument up and down and hitting with thumbs. The word literally means to gather; pronounced koo-chahn-gan-nya.

*Kupungua akili* – running crazy, a common illness caused by *djinn*; pronounced koo-poon-goo-ah ah-kee-lee.

*Kutembeza* – the second stage of drumming for each *jinni* called in a *Kayamba*, consists primarily of hitting the instrument with thumbs. The word literally means to accompany; pronounced koo-tehm-beh-zah.

*Kuzumira* – the first stage of drumming for each *jinni* called in a *Kayamba*, consists of shaking the instrument back and forth; pronounced koo-zoo-meer-rah.

*Liminality* – a period of time during a ritual, which lacks social and cultural norms.

*Lingua Franca* – French for the de facto connecting language of an area despite multiple local languages. Here, *Kiswahili* is the *linga franca* of East Africa; pronounced ling-gwa frahnk-kah.

*Marashi jabal* – a sweet smelling perfume used to call and calm *djinn*; pronounced mah-rah-shi jah-bahl.

*Mchawi* (s) – a witchdoctor that does *uchawi*; plural: *wachawi*; pronounced m-chah-wee.

*Mganga* (s) – Traditional Medicine Practitioner of the Swahili coast, defined as “witchdoctor” by Western society and thus often comes with a negative connotation, especially when a Kenyan is talking with a Western-bred individual; plural: *waganga*; pronounced m-gong-ga

*Mganga ya kienyeji* (s) – a broad term for a TMP. “Kienyeji” means traditional or indigenous, and this kind of doctor may work with herbs, *djinn*, and/or the Qur’an; plural: *waganga wa kienyeji*; pronounced m-gong-gah wah kyen-yej-jee.

*Mganga ya kitabu* (s) – a type of TMP who uses “kitabu,” or the book (Qur’an) to cure and protect patients; plural: *waganga wa vitabu*; pronounced m-gong-gah wah kee-tah-boo.

*Miliki* – ownership, used to describe the relationship between *djinn* and their human healers; pronounced mee-lee-kee.
Mzimu – a house or shrine built as a home for the djinn once the initial contact and connection is made with the TMP. When visiting the mzimu, it is important to announce one’s presence by saying hodi (I am here!) three times each before entering and removing shoes; pronounced m·zee·moo.

Mzunguu (s) – a European or any other white person. This phrase is the most common identifier for a white person in East Africa; plural: wazunguu; pronounced m·zoong·goo.

Ngata – a type of hirizi that protects children from djinn of the water and is primarily for children under two months. Ngata consists of a piece of cloth tied around leaves and herbs, and is worn on the arm. Frequently the blood of a chicken is also put on the cloth; pronounced n·gah·tah.

Orisha – drumming and dancing ceremony for the Santeria people in Cuba that calls the spirits to possess a participant; pronounced ohr·eesh·ah.

Panole – a type of hirizi that protects children from djinn of the land. This amulet is composed of a small stick with a whole in it. This stick is tied by string around the waist or the leg of children; pronounced pah·noh·lay.

Shirk – something against the power of Allah, in this case associating God’s power with djinn; pronounced sheerk.

Swahili – denotes a tribe located on the coast of Kenya, Tanzania, and Mozambique. This is different from the language, which I refer to as Kiswahili; pronounced swah·hee·lee.

Tabula Rasa – blank slate; pronounced tab·yoo·lah rah·sah.

TMP – Traditional Medicine Practitioner, includes waganga wa vitabu, waganga wa kienyeji, and any kind of Swahili doctor that is separate from allopathic medicine.

Ubani – Comes from the deep seas, by one TMP’s explanation was eaten by sharks and vomited, very expensive; pronounced ooh·bah·nee.

Uchawi – black arts, as defined by the colonial government of Kenya. For the purpose of this study, I will designate it as witchcraft and as a separate entity from uganga.

Udi – a type of incense used in ceremonies to summon the djinn; pronounced ooh·chah·wee.

Uganga – white medicine (as opposed to the black magic of uchawi), as defined by the colonial government of Kenya, which is practiced by the “harmless medicine man;”² pronounced ooh·gong·gah.

Ustaarabu – Civilized, comes from the Kiswahili term for Arab; pronounced ooh·stah·ah·rah·boo.

Uvumba – “the scent maker for the devil,” incense used in ceremonies to bring the djinn; pronounced ooh·voom·bah.

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APPENDIX II: SURVEY QUESTIONS USED (English, Kiswahili)

It is important to note both the English and Kiswahili versions of this survey because although answers were received in the English translation, the questions were asked in Kiswahili. Certain words, such as *mafua* and *homa* have multiple English translations. They were intended as fever and flu, respectively, but depending on the location and dialect of the region can be switched in meaning or also indicate a number of symptoms such as headache, runny nose, fever, general aches, and more. *Homa* is often associated with malaria, but can also be a separate symptom group. Thus, the answer of the participant may have depended on their particular definition of the Kiswahili word.

What is your name? *Unaitwaje?*
How old are you? *Una miaka ngapi?*
Where were you born? *Ulizaliwa wapi?*
How many children do you have? *Una watoto wangapi?*
Did you go to school? If so, until what year? *Ulienda shule? Mpaka wapi?*

If your child had fever, what would you do? *Kama watoto wako wakiwana mafua, unafanya nini?*
What is the cause of fever? *Sababu ya mafia ni nini?*
If your child had worms, what would you do? *Kama watoto wako wakiwana minyoo, unafanya nini?*
What is the cause of worms? *Sababu ya minyoo ni nini?*
If your child had malaria, what would you do? *Kama watoto wako wakiwana malaria, au homa, unafanya nini?*
What is the cause of malaria? *Sababu ya malaria ni nini?*
If your child were to faint, what would you do? *Kama watoto wako wakiwana kuzirayi, unafanya nini?*
What is the cause of fainting? *Sababu ya kuzirayi ni nini?*
If your child were to run crazy, what would you do? *Kama watoto wako wakiwana kupungua akili, unafanya nini?*
What is the cause of running crazy? *Sababu ya kupungua akili ni nini?*
If your child had diarrhea, what would you do? *Kama watoto wako wakiwana endesha anaharisha, unafanya nini?*
What is the cause of diarrhea? *Sababu ya endesha anaharisha ni nini?*
If your child had chest pain, what would you do? *Kama watoto wako wakiwana kumwa nakifua, unafanya nini?*
What is the cause of chest pain? *Sababu ya kumwa nakifua ni nini?*

What do you think is the biggest illness in Shirazi? *Mgonjwa kubwa katika Shirazi ni nini?*
Have you ever used traditional medicine? *Ushwahi kutumia dawa zakienyegi?*
Have you ever visited a Traditional Medicine Practitioner? *Umaenda kwa waganga?*
When you had a child, did you use *irizi?* *Wakati ulizaa mtoto, ulitumia irizi?*
APPENDIX III: DEMOGRAPHIC DATA OF SURVEY PARTICIPANTS

Distribution of Survey Individuals: Shirazi Regions

- Mwachimbuwa: 6%
- Taveta: 10%
- Mkajuni: 8%
- Mashamba: 33%
- Pwani: 16%
- Kakira: 12%
- Mangawani: 15%

Education Levels

- None: 37%
- Standard 1 - Standard 4 (Equivalent to grades 1-4): 9%
- Standard 5 - Standard 8 (Equivalent to grades 5-8): 36%
- Form 1 - Form 4 (Equivalent to grades 9-12): 16%
- Adult Education: 2%

Age Distribution

- 19 or Below: 6%
- 20 - 29: 31%
- 30 - 39: 27%
- 40 - 49: 21%
- 50 - 59: 10%
- 60 - 69: 4%
- 70 and Above: 1%
APPENDIX IV: HOUSEHOLD SURVEY RESPONSES

Participant Responses of Most Pressing Illnesses in Shirazi

Figure 1: Most Pressing Illnesses Cited by Participants in Shirazi – When asked for the most prevalent health problem in Shirazi, 48% mentioned malaria and 51% mentioned homa, though homa is often considered a symptom of malaria. Listed are those diseases that were responses from at least two different participants. Villagers were not limited to one response nor were they given a list of illnesses from which to choose.

Figure 2A: Cause of Malaria

Figure 2B: Preferred Treatment

Figure 2A and 2B: Based on participant responses, 83% stated that mosquitoes were the cause of malaria. This belief likely comes from extensive government and allopathic medical campaigning. An extensive number of the Shirazi villagers claimed to use a bed net, though some cited cost as an issue of access. The nearby
Msambweni District Hospital distributes free mosquito nets for all visitors of the maternal child clinic. Nearly 90% of participants said that they would send their child to the hospital or some kind of allopathic medical facility if they realized they had malaria, however in reality this number is likely much lower due to cost barriers.

**Figure 3A: Cause of Chest Pain**

**Figure 3B: Preferred Treatment**

**Figure 3A and 3B:** Shirazi villagers responded ambiguously regarding the cause of chest pain. The most common response was the weather/cold, at 27%, while the second most common responses were *homa* and hard work, at 16% each. This demonstrates the concept of cold and change in weather as a method of disease causation in Swahili society. While the majority of participants, 62%, said they would visit the hospital or some kind of allopathic medical facility for chest pain, it is likely that this number would be much lower in reality due to issues of accessibility such as cost and distance.

**Figure 4A: Cause of Running Crazy**

**Figure 4B: Preferred Treatment**

**Figure 4A and 4B:** While 32% of villagers stated malaria in the head as the cause of running crazy, this disease is most often associated with *djinn*. This is according to
those villagers with whom I had the strongest relationship, as well as my waganga informants. Of the participants, 42% said they did not know the cause of the problem, which I would suggest is because they believed it was the djinn but felt reluctant to say this to a Western outsider who they perceived as having differing views. Nearly 6% of participants stated the cause of running crazy as lack of blood, which may be a connection with the concept of djinn as it is believed that a person “runs crazy” in order to run towards a jinni who will then steal the blood of a person. While 64% of participants said they would send the person to the hospital or some other kind of allopathic medical facility, 16% said they would send them to a TMP. Over 12% stated they would send the person to the only mental hospital in Kenya, Portrice.

**Figure 5A: Cause of Fever**

- Dust: 48%
- Weather: 22%
- Coughing: 5%
- Homa: 11%
- Unknown: 11%
- Other: 3%

**Figure 5B: Preferred Treatment**

- Hospital: 26%
- Non-prescription Medication: 72%

**Figure 5A and 5B:** The most common perceived cause of fever was dust, at 48%. I suggest this is because Shirazi is a homogenous Muslim population where cleanliness and thus purity is of high importance. However the second largest causative factor at weather, at 22%, which relates to the idea of cold/changes of weather as a concept of disease in Swahili society. Fever was the one discussed illness that had an overwhelming response of a preference towards home care, at 72%, by purchasing non-prescription medication from the shop.

**Figure 6A: Cause of Diarrhea**

- Dirtyness: 69%
- Unknown: 16%
- Mangos: 4%
- Other: 6%
- Change in Environment: 5%

**Figure 6B: Preferred Treatment**

- Hospital: 64%
- At-Home Remedy 1: 20%
- At-Home Remedy 2: 6%
- Non-prescription Medication: 10%
Figure 6A and 6B: Nearly 70% of participants cited dirtiness as the cause of diarrhea, stratified as 52% stating dirty food or water, 6% citing dirty stomach, and 11% stating general dirtiness. Some participants also cited flies as the cause. This may be because Shirazi is a homogenous Muslim community that values cleanliness as a top priority. While 64% of participants stated that they would visit the hospital or another allopathic medical facility if their children had diarrhea, this number is in reality much lower due to issues of cost. Nearly 20% of participants said they would use a remedy of boiling water with sugar and salt, labeled Mother’s Medicine 1, though again this number is likely much higher due to ease of accessibility. A remedy of boiled leaves, labeled Mother’s Medicine 2, also received 6% of the participant responses. These are just two of the many at-home remedies understood and utilized by the mothers of Shirazi.

Figure 7A: Cause of Fainting

- Unknown: 36%
- Other: 18%
- Lack of blood: 6%
- Weather: 12%
- Homa: 10%
- Spirits: 4%
- Dizziness: 4%
- Surprise: 5%
- Pressure: 5%

Figure 7B: Preferred Treatment

- Hospital: 37%
- First Aid: 21%
- Pour Water: 17%
- TMP: 9%
- At-Home Remedies: 5%
- Qu'ran: 1%

Figure 7A and 7B: There was little consensus regarding the cause of fainting amongst the Shirazi participants, however the majority of people, 33%, stated that they did not know the cause. This may have been because many of them believed that djinn were the cause, as was explained by 4% of the population and the interviewed TMPs. This could potentially be verified by the fact that 6% of people stated that fainting was caused by a lack of blood, and it is commonly believed that djinn lack blood and attack humans for this form of sustenance. While 37% of people said they would go to the hospital, 21% said they would perform some kind of first aid and 17% said they would pour water on the patient. This suggests that fainting is considered to be a disease easily dealt with in-home, which is further verified by the 5% who said they would use different methods of mother’s medicine.
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