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Stuck in the Clinic: Vernacular Healing and Medical Anthropology in Contemporary sub-Saharan Africa

While vernacular therapeutics had long been a topic of interest to many writing about medicine and healing in Africa, with a few exceptions most recent anthropological writings on medicine in Africa are focused on biomedicine. In this article, I trace this shift back to the turn of the millennium and the convergence of three events: the emergence of global health, the accession of the occult economies paradigm, and critiques of culturalism in medical anthropology. I argue that these three shifts led to research projects and priorities that looked different from those defined and undertaken as late as the late 1990s. While seeking to avoid the errors that could come with writing about vernacular therapeutic traditions in Africa as bounded comprehensive systems, I argue that there are empirical, political, and practical reasons why medical anthropologists may want to reconsider our collective research priorities. [Africa, vernacular therapeutics, global health, occult economies, culturalism]

In July 2016, I returned to Uganda to continue work on a collaborative ethnographic study about the means through which people there are attempting to resolve alcohol-related problems in their lives. The previous summer, my collaborator George Mpanga and I had spent much of our time at the alcohol and drug unit (ADU) of Uganda's primary psychiatric referral hospital. We interviewed nurses, psychiatrists, activists, and patients. We sat on plastic chairs listening to didactic presentations about the causes of addiction and the physical effects of alcohol and tobacco on the body. We participated in small group discussions with patients as they talked about their fears concerning what might happen to them when they returned home.

While at the ADU, I felt I was in a relatively familiar milieu. By familiar, I mean less that I recognized the concepts and therapeutic forms as similar to those I knew from the United States, but rather that the spaces I inhabited there and the people I spoke with felt similar to those I was used to reading about in contemporary writings in the medical anthropology of sub-Saharan Africa. This was a clinic. These were biomedically oriented professionals. I knew how to ask questions that might reveal the genealogies of the concepts and examples that trainers wrote on

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 00, Issue 00, pp. 1–17, ISSN 0745-5194, online ISSN 1548-1387. © 2018 by the American Anthropological Association. All rights reserved. DOI: 10.1111/maq.12467

flip charts. I knew how to think about the trajectories of the therapeutic concepts and methods that were shaping this particular version of addiction (Raikhel 2013). I knew how to mark the interface and subtle misalignments between Kiganda concepts like *obuzaale*—an inborn quality—and genetics. I knew how to think about the new forms of biosociality (Rabinow 2005) being crafted by Alcoholics Anonymous groups and their associated NGOs. So far so good.

Over the year that followed, George continued work on our ethnography of the ADU, as well as two Christian churches where we had also worked in 2015. At the same time, he started to follow up with a few leads about the ways herbalists and *basamize*, ritual specialists who may also have capacities for divination through mediumship, treat those who come to them with problems related to drinking and substance use.

On my first day back in Kampala in 2016, George and I decided to visit the home and *ssabo* (shrine) of one of these *basamize*, Jjajja Kasumba,¹ on our way back from our first visit to the national psychiatric hospital. Kasumba was the most prominent of the *basamize* that George had been in touch with thus far, and after a long series of preliminary visits, it seemed like he might be open to helping us with our study. Noah, our driver and friend, parked his car on the side of one of the main roads in one of Kampala's posh southern neighborhoods, and George and I proceeded on foot down the steep dirt road that led to Kasumba's gate. Near the bottom of the hill, we arrived at a small opening amid a veritable wall of lush green vines. Next to the opening was a large *mutuba* tree, the tree used for making bark cloth, filled with the small hanging globes that are the nests to the bright yellow weaver birds. Stooping down to pass through the tunnel of vines, we entered the compound of round, brick, tin-roofed huts. There were several fires burning, and the strange flat smell of an unfamiliar smoke hung in the air. Along the side wall of the compound was a long wooden bench where three women were sitting smoking long pipes.

As we entered, a man with a slight muscular build wearing a worn polo shirt and plaid pants approached us and greeted George warmly. He had a large bump on the side of his foot that caused him to limp slightly. George introduced him to me as Mayanja, one of Kasumba's assistants. Mayanja told us that Kasumba was away for the day but that he would be back tomorrow. He said that he and one of the other assistants could talk with us since Kasumba was gone. Mayanja invited us to enter the *ssabo* and we removed our shoes at the door.

Kasumba's *ssabo* is a spacious circular room with a high roof made of iron sheets. It was a cool day and it was cooler still inside. The roof of Kasumba's *ssabo* is held up by four smooth wooden poles. At the tops of the poles and all around the circumference of the roof are dry calabashes and bags made of different kinds of materials: plastic bags, baskets, fabric, and soft brown bark cloth. The floor of the *ssabo* is made of packed dirt, and it was covered wall to wall by large mats made of different plastics and fibers in varying states of repair. In the far-left corner toward the back, there is a square area covered with white animal hides surrounded by a row of thin iron spears with different kinds of points. We all four sat on the mats with our legs tucked to the side, shifting from side to side to reposition sore and sleeping feet periodically over the course of the long conversation.

I had only entered a *ssabo* once before, the previous summer when George and I went to visit another healer, who George quickly decided was not only a fake,

but a lazy and untalented fake at that. Here, sitting on this mat in this cool dark room talking with Mayanja, I felt astonished by my own lack of knowledge. It was not only that the specifics of this religious and therapeutic forms were new to me. Rather, I found myself in a space quite unlike the spaces I had become used to reading about.

At first, I wondered if what I had seen in Kasumba's shrine was little more than a fragile remainder of practices that were largely collapsing in Africa. Yet, such an assumption stands in tension with estimates that on average there are nearly 80 traditional healers for every doctor in most African countries (Abdullahi 2011). The challenge of estimating just how often people visit non-biomedical practitioners across this vast and diverse region is so difficult that many authors often rely on a long outdated and contested 1983 figure that estimated that 80% of Africans rely on traditional healers as a source of primary health care (Oyebode et al. 2016; World Health Organization 1983). While I would hesitate to use the 1983 statistic, the smaller claims of more recent quantitative studies similarly attest to the continued importance of a wide variety of vernacular healing practices.² For example, a retrospective quantitative study of traditional medical therapy utilization in Ghana reported that 86% of people had used traditional herbal and spiritual interventions alongside biomedical therapies during the prior year (Gyasi 2015). Kasumba, like the other basamize we have worked with over the past two years, counsels people who come to him for help with a wide range of maladies and misfortunes. As a medium, he works through dreams and through possession by *lubaale* spirits that communicate with the other spirits who may be troubling his clients. Where he diagnoses a person with problems related to alcohol or other drugs as having a problem with a spiritual origin, the *lubaale* spirits *Kawumpuli* and *Bamweyana* are often involved. These spirits are princes who drink through those they possess, like straws, but with proper and regular offerings, their thirst can be slaked in ways less troubling to the living. Members of Kampala's numerous Pentecostal and Charismatic churches are similarly worried about the effects of *Kawumpuli* and *Bamweyana* in people's lives, but they see deliverance as the means to freedom from these demands.

In other cases, Kasumba determines that the problem is not spiritual at all, and suggests that his clients seek out the care of an herbalist. Like these patients, we have also found ourselves spending time the small shops of herbalists like Nankya Elizabeth and in the homes and workplaces of the patients she has treated. Among other things, Nankya produces and sells herbal emetics designed to end drinking problems through the administration of a few vomit-inducing sensorium-reordering doses to be given by a friend or relative in a person's favorite alcoholic beverage. These emetics are but a small fraction of the medicines sold by the herbalists we work with, and herbal medicines are also gathered and prepared by friends and relatives. While the vast majority of books, journal articles, and conference papers given by anthropologists on this topic might make it seem as though understandings of health and healing in Africa are shaped by a biomedical hegemony, the situation is clearly more complicated.

I also wondered if my sense of a discrepancy between the therapeutic landscape of contemporary Kampala and the current literature might simply be an effect of selective reading. Had my own preferences and citation circles left some authors and works just beyond my field of vision? Yet, as I searched and read, it seemed

less that my sense of an absence of recent work in this area was the result of my individual training and reading practices, than that it was overdetermined by the way the discipline had itself evolved.

Vernacular therapeutic practices had once been a topic of great interest to anthropologists and historians³ writing on medicine and healing in Africa (Ashforth 2000; Devisch 1993; Evans-Pritchard 1937; Feierman and Janzen 1992; Janzen 1982, 1992; Klaitz 2010; Langwick 2011a; Livingston 2004, 2005; Luedke 2007; Luedke and West 2006; Marsland 2007; Masquelier 1995, 2001; Stoller and Olkes 1989; Turner 1968; West 2007; Whyte 1997). These works were central to important debates concerning questions of rationality (Evans-Pritchard 1937), foundational to the development of major schools of anthropological theory such as symbolic anthropology (Turner 1968), and crucial to anthropological understandings of how socio-cultural orders are reproduced and transformed (Comaroff 1981).

Into the 1990s, anthropologists were designing ethnographic studies that offered sophisticated analyses of the battles over truth and power that shape the ontological politics of healing in Africa (Langwick 2011a). While many of the works researched in the 1990s were still making their way through the publication process well into the new millennium, research projects that were conceived and gestated after the turn of the millennium were far less likely to consider vernacular practices in ways and in spaces that are not already defined by the biomedical. With a few exceptions, many of which consider Christian healing practices rather than indigenous ones (Boyd 2015; Hannig 2017; van Dijk et al. 2014), we now rarely find non-biomedical practices described as part of lived therapeutic ecologies. While these earlier works still have much to offer, we can neither assume that their descriptions are consistent with present practice, nor that our present theoretical concerns would not cause us to notice quite a different set of details.

The decreasing focus on vernacular healing in medical anthropology is by no means limited to sub-Saharan Africa. Much of our work as medical anthropologists around the world is now focused on the lives of the health workers, patients, and things in hospitals, clinics, and health-related non-governmental organizations (Lock and Nguyen 2010), a trend that may be an unintended consequence of the otherwise laudable shift toward critical medical anthropology (Das and Han 2015) and a growing division between medical anthropology and the anthropology of religion⁴ (Whitmarsh and Roberts 2016). Works such as those by Elizabeth Roberts (2012), Sherine Hamdy (2012), and Alice Street (2014) show us how non-biomedical ideas and practices shape the life of the clinic, but still the clinic remains the site and limits the discussion of these elements to their appearance in spaces already defined by biomedicine.

But, while medical anthropology's increased focus on biomedicine does extend beyond Africa, there are several factors that make this trend especially pronounced in this region. As I discuss further below, one of these factors is Africa's role as the iconic site for global health intervention, a fact that is at least in part due to Africa's association with the AIDS epidemic. In addition, we might consider the marginalization of the vernacular therapeutic traditions that colonists, missionaries, and some contemporary Africans associate with witchcraft (Langwick 2011a; Tilley 2011). Vernacular therapeutic practices have also come under pressure outside of Africa (Adams 2003); non-biomedical practices in countries like Thailand, China,

and India also enjoy a much greater level of official recognition (Osseo-Asare 2014) and are much more likely to be taken seriously as alternative forms of care in global processes of exchange and translation. Finally, the striking linguistic divergences between biomedical and vernacular therapeutic spaces in Africa make having an excellent translator or fluency in a local language much less of a necessity if one is willing to limit one's inquiries to spaces dominated by biomedicine. While there are some foreign field sites that require a degree of fluency to work on nearly any project, the linguistic situation in some African countries makes it possible to conduct certain kinds of work with very little knowledge of any local language. Acquiring linguistic fluency in languages not typically offered by American universities has become increasingly difficult with new expectations of time-shortened degrees, and this has likely changed many research trajectories.

Although biomedicine is present and cannot be ignored, attending to the ways in which its presence impacts places like Kampala and articulates with other traditions has displaced other possible concerns. I have no interest in questing after a pure or unadulterated version of traditional medicine, but there may be a great deal to be learned by exploring the more expansive sources from which the fragments that appear in clinical spaces come. Since the end of the 1990s, when projects on vernacular herbal traditions have been conceived, these traditions are most prominently engaged at sites where Africans and others are working to market and test herbal medicines through bioscientific epistemologies and techniques (Dronoy 2014; Langwick 2011b; Osseo-Asare 2014)—or in ways that seek to interpret witchcraft accusations as reflective of broader critiques of globalization, capitalism, and spectacular forms of inexplicable and unjust accumulation (Smith and Ngeti 2014). While seeking to avoid the errors that may come with writing about vernacular therapeutic traditions in Africa from a perspective that treats them as bounded comprehensive systems, in this essay, I seek to explore how and why medical anthropologists working in Africa turned away from places like this small urban ssabo and toward the clinic and why it might be important to reconsider this decision.⁵

How Did This Happen?

Explaining why something has been neglected is more difficult than explaining why something has captured our attention. In explaining why this shift has occurred, I first argue that it was less that vernacular healing practices were consciously rejected as a legitimate topic for study in the medical anthropology of sub-Saharan Africa than it was that another topic, namely the extension of biomedicine through the practice of global health, a phenomenon of real interest and importance, captured our attention. Second, I claim that where forms of vernacular practice, which might have previously been engaged through a language of healing were to be engaged, the “occult economies” framework bore with it such power that it eclipsed all other ways of engaging this area of life. Finally, arguments concerning the dangers of “culturalism” and the real need for more substantial engagements of political economy made explorations of vernacular healing cultures seem suspect. I argue that these three trends, over time, have produced a situation in which it has become more difficult to imagine or conceive of projects that attend to these other ways of healing, knowing, and being on their own terms.

Global Health

Beginning in the late 1990s, several factors, including the end of the cold war and the increasing importance of neoliberalism, brought about changes in how members of the international community approached and defined problems related to health and development. Neoliberal structural adjustment programs resulted in extreme cuts in public spending on health and welfare in many developing countries. Instead of reinstating public spending through the state, key members of the international community, including 1998–2003 WHO Director-General Gro Harlem Brundtland, sought to fill these gaps with a patchwork of public–private partnerships and non-governmental initiatives, which they expected to be more scientific, less vulnerable to corruption, and less likely to be determined by the political interests of individual states (Brown et al. 2006; Cueto 2013). The shift to global health also entailed an increasing emphasis on particular kinds of quantitative metrics, such as DALY and QALYs, and proofs of efficacy, such as randomized controlled trials (Adams 2016).

This moment of enthusiasm for global health was preceded by efforts made under the sign of “international health” (Brown et al. 2006) and decades of colonial and missionary medicine before that (Hunt 1999; Tilley 2011; Vaughan 1991). While global health brought with it some changes, such as those mentioned above, the argument that I want to make here about global health’s relationship to vernacular therapeutics is less that global health erased vernacular healing practices in ways that fundamentally differed from the brittle collaborations undertaken during colonialism (Tilley 2011) or the era of international health (Janes and Corbett 2009), than that new conceptual and methodological trends changed how medical anthropologists engaged with it. These trends prized the careful tracing of transnational movements of heterogeneously assembled people, ethics, technologies, practices, and forms of reasoning and asserted utility and necessity of thinking about the contemporary as made up of an ever-changing set of unstable and highly mobile global assemblages (Ong and Collier 2005). The newly valued field of global health was a perfect match for this new conceptual focus.

While anthropologists like George Foster had long noted the importance of studying the cultures of the bureaucratic practices of international health (1976), in this new wave of work, global health practitioners and field sites moved to the center of anthropological accounts, and vernacular practices moved to the margins (Benton 2015; Biruk 2018; Brada 2011; Crane 2013; Livingston 2012; McKay 2018; Nguyen 2010; Wendland 2010; Whyte 2014). In attending to the role of research in global health assemblages, they have also brought African field sites into the ever-expanding field of science and technology studies (Biruk 2018; Geissler 2015), while at the same time the growing anthropological interest in science and technology studies has likely played a role in inspiring these anthropologists to frame their projects in the ways that they have.

As noted above, Africa has arguably been at the center of this newly configured field of global health and because of this work on global health has perhaps had its most significant influence on the medical anthropology of this region. In large part, this stems from the role played by the AIDS epidemic in Africa and the ways in which U.S. PEPFAR funding has shaped the practice of health care there. As Johanna Crane writes in *Scrambling for Africa*, from the standpoint of global health practitioners

“[AIDS] seems distinctly rooted in place; its primary symbolic register is not so much global, but African” (Crane 2013, 152). While many of the earlier ethnographies carried out in the “age of AIDS” focused on a diverse range of issues and modes of care, the emergence of anti-retroviral therapies (ARVs) changed both the course of the epidemic and the shape of the ethnographies written about it in this new “age of treatment” (Moyer 2015). Most of the later works focus specifically on the ways funding for treatment has shaped the lives of patients, practitioners, and institutions.

Acknowledging that these excellent and nuanced ethnographies have offered critical insights into the subtle distributions of health and harm, care and abandonment in contemporary sub-Saharan Africa, nevertheless in this article I want to point out that the shift in focus within medical anthropology to such topics has eclipsed the vast range of field sites and lived experiences of health seeking that are also eclipsed by global health itself. While we point to the problem of the narrow biomedical conceptualization of health (Baer et al. 2016) and often cite earlier ethnographers and historical works on health and healing in Africa, which offer a powerfully different vision of health and healing, contemporary medical anthropologists working in Africa only rarely attend to such visions as they are lived in the present.

Occult Economies

With several key exceptions (Sanders 2003, 2015; West 2007), when narratives that might have once have been framed as related to vernacular therapeutic practice are discussed by anthropologists, they are increasingly discussed primarily as metaphoric critiques of modernity and capitalism. Over the past two decades, the more open-ended approach to phenomena like possession that was established over the 1980s and 90’s (Boddy 1994) has largely been eclipsed in the anthropology of Africa by the rise of an approach focused primarily on witchcraft and the ways in which it functions as an idiom responding to the experiences of dispossession wrought by neoliberal capital. The numerous essays and books that were inspired by Luise White’s *Speaking with Vampires* (White 2000), Jean and John Comaroff’s path-breaking work on “occult economies” (Comaroff and Comaroff 1999), and Geschiere’s now classic *The Modernity of Witchcraft* (Geschiere 1997) have no doubt made an important contribution to the study of the lived realities of and critical engagements with colonial and post-colonial dispossession in sub-Saharan Africa. Yet they have also impacted the ways in which such phenomena are approached in our discipline in ways that may not have been their intent. In short, when we think about witchcraft largely as a metaphor for the new forms of inequality and extraction generated by modernity and neoliberalism, our ability to think about the full range of meaning and experience associated with these practices is compromised. It is less that these authors misread their materials, than that in overestimating the generalizability of this argument we have undermined our ability to read vernacular healing on other terms.

In my own experiences living and conducting research in Kampala, there have certainly been moments where such arguments felt like obvious fits for the rumors and tabloid news stories that at certain times filled the taxis, newsstands,

back stoops, and radio programs. The rumors surfaced by the May 2017 death of the Ugandan tycoon Ivan Semwanga easily fit such an analysis. Semwanga was incredibly wealthy and was said to be one of the “illuminati” who gained his wealth by sacrificing one of his children to an underwater king. Such a sacrifice did not typically involve killing the child sacrificed; more often, such a child was said to become mentally ill or alcoholic. While the child suffers, the parent who has made the sacrifice dotes on them, not so much from guilt but from gratitude to that child as the source of all of their wealth. When someone has unexplainable riches and one of their children has such a problem, rumors start to circulate.

And yet, these stories of accusation, suspicion, and violence are not the only stories there are to tell. Nor are they the only way to understand the stories of witchcraft, child sacrifice, and cannibalism that circulate. Struggling over this argument with George and Noah over hot cups of milky tea and chapatti at the Makerere University canteen on the morning of my departure in 2016, I presented the occult economies argument to them to see how it might match with the stories of witchcraft and cannibalism that were raised by a trip to an area of the country known for *abasezi*, people who are said to dance naked in the night as they consume dead bodies taken from fresh graves. As we sipped our tea and waited for our university colleague to emerge from a meeting, I presented the argument Jean and John Comaroff made in “Occult Economies and the Violence of Abstraction,” much as I do when I teach this breathtaking article to my undergraduates each spring. I asked them how they thought it might relate to the stories of witchcraft that circulate in their own worlds. “These stories aren’t metaphors,” George said. “We do use metaphors all the time, and when we do, we know we are doing it. But when we talk about *abasezi*, we aren’t making a critique of the economy, we are talking about *abasezi*. If we wanted to talk about the economy we would talk about it directly.”

Like the audience of local researchers in Mozambique that rejected Harry West’s Turnerian interpretations of the symbolic importance of sorcery lions (West 2007, 5), George and Noah objected to the necessity of using a symbolic or metaphorical logic when approaching narratives about *abasezi*. While I would not want to say that witchcraft rumors, such as those that circulated around Ivan Semwanga, are *never* at least partially a critique for the unexplained and uneven distributions of wealth that shape the contemporary world, I do ask that we consider the ontological certainties that underlie the witchcraft-as-metaphor position. As Bruce Kapferer notes, these arguments reintroduce a sort of psychological functionalism while also “turning away from the particularities of the phenomena . . . to lump them together under the sign of the irrational, which must await the true understanding of the anthropologist, the author of the rational” (Kapferer 2003, 18–19). Todd Sanders similarly calls for work on contemporary vernacular healing practice which “may well be part of modernity, but by no means needs to be *about* modernity” (Sanders 2003, 338). Like Sanders and Kapferer, I argue that staying open to the meaning, effects, and origins of any given phenomenon is a necessary first step toward reopening our understanding of the contemporary practice of ever-shifting vernacular therapeutic healing.

Culturalism

If the excitement captured by global health and the occult economies argument pulled the attention of medical anthropologists working in sub-Saharan Africa away from attending to vernacular healing practices, arguments concerning the dangers of culturalism may have further and more explicitly pushed our focus away from these topics of inquiry. Within medical anthropology, scholars like Charles Briggs have shown how the embrace of “cultural reasoning” enables the transformation of “moral and political crisis into a means of consolidating . . . power . . . and legitimating and naturalizing . . . acute social inequality” (Briggs 2001, 666–67). Through the deployment of cultural reasoning, states and other powerful actors can effectively deflect attention from growing inequalities linked to processes of globalization and the spread of neoliberalism by instead focusing arguments and investigations of the causes of epidemics and other health problems on cultural practices and beliefs. Briggs’ arguments draw on the writings of Paul Farmer who has famously argued that health workers, anthropologists, and politicians have repeatedly mistakenly seen evidence of structural violence as the outcome of cultural difference (Farmer 1992, 1999).

In Didier Fassin’s most explicit critique of the ideology of culturalism deployed by development workers, public health practitioners, and some anthropologists, he refers to “a combination of a process of *reification of culture*, rendered concrete by objects (traits, variables, behaviors), which can be isolated from a given reality, and a process of *cultural overdetermination*, which takes the form of explanations (factors, obstacles, resistance) that stand out among all possibilities” (Fassin 2001, 302). Like Briggs and Farmer, Fassin’s critique points to the ways in which this allows for diminishing attention to political and economic determinants and to the cultures of health and development institutions themselves. In place of this approach to culture, Fassin advocates an approach that would look first to the structural conditions, which underlie cultural patterns and practices (Fassin 2001, 312) and second toward an analysis of the political uses of cultural reasoning (Fassin 2001, 313). Here we can again think back to Briggs (2001).

The success and importance of this argument cannot be understated. It is an approach that has yielded insights of tremendous practical and theoretical import, as was clearly on display during the 2014 Ebola epidemic in West Africa (Benton and Yi; Dionne 2015; Jones 2014). In many ways, critiques like those made by Fassin, Briggs, and Farmer at the turn of the millennium also paved the way for the helpful shift from cultural competency to structural competency (Metzl and Hansen 2014).

This focus on political economy and structural violence shapes the way I structure and teach my introductory courses in medical anthropology, and I would not want our field to be without it. And yet, there is something important that has been lost in this shift. In opposing what Fassin, Briggs, and Farmer termed culturalism, and instead of looking almost exclusively at the structural factors underlying health disparities, the political uses of culture, and the cultures of biomedicine, we have perhaps become increasingly disinterested in describing and analyzing non-biomedical approaches to healing. While earlier works in this area may have appeared to be apolitical or shaped by distracting fascinations with the exotic (Fassin 2001, 303),

there are important pragmatic, empirical, and political reasons to open space for work in this area in anthropology's future.

So, Why Does This Matter?

Given the great fruits yielded through the critical study of biomedicine and global health and the risk that the errors of culturalist reasoning might be smuggled back in with a renewed focus on vernacular healing practices, we might be wary of returning to this area of study. What are the stakes of this move away from the study of vernacular healing practices *as healing practices*? What might we gain by again granting these practices a more central place in Africanist medical anthropology? In the last section of this article, I will argue that these stakes are empirical, political, and practical and that they are significant enough to merit a reconsideration of some of our research priorities.

Empirical

While there are certainly exceptions, at an empirical level, we are quite often leaving major gaps when it comes to describing how many contemporary Africans, both urban and rural, live in relation to the vernacular therapeutic offerings in their cities, towns, and villages. We often tell our readers that the medical offerings are plural and that they are shifting, but in the most recent writings on medical care and healing in sub-Saharan Africa, the descriptions of biomedical and developmental spaces are typically far more detailed than descriptions of more vernacular sites. In some cases, scholars who have produced groundbreaking work in the anthropology of biomedicine and global health (Livingston 2012; Whyte et al. 2014), did earlier work on vernacular practices of health and healing⁶ (Livingston 2005; Whyte 1997) and this allows them to traverse these realms with greater fluidity. Yet, as disciplinary norms have shifted, this pathway has become less common, and younger scholars publishing on global health often lack such prior experience doing research outside of clinics, laboratories, and NGOs.

We know from anthropologists of global health like Adia Benton (2015) that the coverage by biomedicine is radically uneven, focusing on some illnesses, while ignoring others. We need scholarship that describes not only what happens to the few caught up in the biotechnical embrace, but also what happens to the people whose quests for therapy lie primarily outside of it. Given the contingency of global health funding in our current political climate, it may well be that the number of those who find themselves outside of the clinic may be growing rather than shrinking.⁷ Finally, if one of the key things we know about traditional healing practices in sub-Saharan Africa is that they are constantly changing, we cannot let older ethnographic and historical data points serve as a substitute for contemporary ethnographic work when we refer to what may be happening outside of the clinic in the present.

Political

Langwick's work shows us that questions concerning the status of traditional medicine are deeply political ones. They are questions related to a "highly politicized

and intimate battle over who and what has the right to exist” (Langwick 2011a, 232). While medical anthropologists working in Africa have followed Langwick in noting the political stakes of colonial and post-colonial efforts to sever the phytopharmaceutical aspects of African medical systems from their more political and religious elements, we have been markedly less careful about our own continued participation in the dividing practices. Where medical anthropologists and medical historians were once concerned with a broad range of healing practices that blurred the lines between the physical, the spiritual, and the political, more recent works have tended to focus on phytopharmaceutical and the scientific and entrepreneurial practices related to their certification and commodification (Droney 2014; Osseo-Asare 2014). These works are important and may help us better understand new realities on the ground, but they also leave out the vast majority of healers and patients who have no connection to such institutions. Their lives may also reflect new realities that merit our attention, but they are harder to see at a distance.

The stakes of this may be all the more important, given the legacy of AIDS denialism in South Africa. These scandals and rumors did much to delegitimize African healing. While Fassin made important arguments showing the legitimacy of Mbeki’s arguments concerning the inadequacy of etiological arguments concerning the causes of AIDS focused solely on the virus (Fassin 2007). Our own failures to explore vernacular healing practices subtly reinforce the position that African medical traditions are either destructive or, at best, have little to offer in terms of real efficacy.

There are also other dividing practices at stake in contemporary ethnographic writing on hospitals and laboratories linked to questions of time, of tradition, and of modernity. Some of these works seem to say, “Look! Africans are modern too.” These works, are, in this way, not so unlike Manchester School ethnographies produced by the members of the Rhodes Livingstone Institute in their celebrations of Africans embracing modern Western practices, be they ballroom dancing (Wilson 1942), working in a laboratory (Droney 2014), or using a cell phone (Archambault 2017). In so doing, they assert, and often helpfully and accurately so, the similarity, the coeval belonging (Fabian 1983), of certain sites in Africa and in the worlds of their readers, a group who are presumed to be students and faculty members at universities in the Global North.

While there are certainly apartment complexes, shopping malls, NGOs offices, and laboratories in Kampala that easily fit this pattern, there are also places like Kasumba’s *ssabo*. This *ssabo* is not part of the past. It also isn’t in a remote village. It is in the center of Kampala. I could tell you truthfully that Jjajja’s assistants are men who spend much of their time talking about their work as land brokers, poring over sports betting sheets, and attempting to realize their aspirations for music video production contracts. I could tell you about Kasumba proudly telling us about his daughter’s recent enrollment at Makerere University where she was seeking her BA in chemistry. But it is not these things that make Kasumba, his patients, and his assistants coeval members of your own time. They are part of your own time because they are presently living. That they also think deeply and live their lives in relation to spirits and rituals that medical anthropologists working in sub-Saharan Africa rarely write about anymore does not make them less so, and their practices need not be *about* modernity to be part of modernity (Sanders 2003). Part of the studied

ignoring of vernacular healing practices, such as those undertaken by Kasumba and his associates, may be a fear of portraying Africans as essentially irrational or unmodern. But, like second wave feminism that asserted that women could, in fact, be just like men, thus implicitly valuing characteristics that were associated with men, in our avoidance of this area of healing and harming we too subtly and perhaps inadvertently shore up the value and legitimacy of modern Western practices.

Practical

These erasures are problematic not only for the political and empirical reasons laid out above, but also for the pragmatic reasons long championed by anthropologists. Quite simply, vernacular healing practices in Africa may have much to teach us about how people anywhere might best respond to the illnesses that shape and cut short our lives. We must not only keep a critical eye on the social determinants of health, the inadequacies of biomedicine, and the global movements of pills and practitioners, we must also look to these vernacular systems as places to learn *from*—and this must be equally true of Africa as it is for Tibet, Nepal, China, or India. We often say that biomedicine discounts these practices, but in ceasing to devote our scholarly attentions to them, we implicitly do the same.

In addition to the political potential of these vernacular practices and etiologies of affliction, we have only begun to explore what these practices might have to teach us in terms of healing our bodies and minds. This may be especially important for those illnesses that biomedicine is not particularly good at addressing, such as pain, addiction, and mental illness. While the global health apparatus is busy trying to export biomedical remedies for these conditions abroad (Watters 2010), even as the efficacy of these remedies has been questioned at home, medical anthropologists might be more involved in exploring how these conditions are approached in places where people have developed different ways of understanding and approaching them. What, for example, might we learn from Julie Livingston's or Duana Fullwiley's (Fullwiley 2010) work on the management of pain in Botswana and Senegal? What is it about the management of schizophrenia in Zanzibar (McGruder 2004) that leads to increased well-being among sufferers and their families? How do practices related to the care of plants and people create new spaces of habitability in an increasingly toxic world (Langwick 2017)? As these citations indicate, there is already some work that hints at these potentials, but there is room for so much more.

Conclusions

In her book, *A Nervous State*, Nancy Rose Hunt urges medical historians working in sub-Saharan Africa to think of their work and its products as a kind of “suturing,” a patchy work of juxtaposing and sewing together heterogeneous sources and sites with the aim of unsettling readers' and viewers' prior understandings and assumptions (Hunt 2016). Anthropologists are no strangers to this sort of work, but if we are to continue to be able take up and think with stories that do not yet

resonate with our available theoretical paradigms, we need to spend as much, if not more, time in the healer's hut as we do in the hospital.

Medical anthropologists are often critical of biomedicine's practices, forms of reasoning, and power. Yet, by eschewing engagements with other modes of healing, we subtly, and perhaps inadvertently, buttress that which we think we undermine. While critiques of development and biomedicine are often focused on the limits of these frames, we now rarely write about what happens beyond them. In so doing, we reinforce the idea that Western ideas, practices, and actors are the things that are most interesting, the things that really matter in the lives of African people.

Biomedicine certainly plays a role in contemporary African life, but if the next generation of medical anthropologists working in Africa becomes too firmly entrenched in the clinic, the discipline will miss out on the tremendous richness that African traditions, hybridity, and cosmopolitanism have historically provided for our thinking about the diversity of human practice and experience. Such work requires sustained engagement with local languages, with the history of anthropology, and with field sites that are less easily visible on maps or in the media. Overcoming these obstacles is not impossible, but doing so will require that we all think carefully about which projects are worthwhile and why it is that we think so.

Notes

Acknowledgments. This material is based on work supported by the National Science Foundation under award no. BCS-1758472 and the University of Virginia. I would like to thank Ira Bashkow, Crystal Biruk, Betsey Brada, Carrie Douglas, Anna Eisenstein, Susan McKinnon, Marisa Mika, George Mpanga, Paul Scherz, Christy Schuetze, Scott Stonington, Tyler Zoanni, and two anonymous reviewers for their constructive comments at various points in the development of this article.

1. All personal names have been changed to protect the confidentiality of those who participated in the study.

2. In this article, I follow Nancy Rose Hunt's use of the term "vernacular" to refer to a therapeutic domain that is sometimes be termed traditional or local (Hunt 2016). Given that these therapeutic forms are constantly moving and changing (Ludke and West 2006) neither traditional or local is exactly right, although it is worth noting that the word traditional is often used by people in Uganda referring to this domain in English. Like Hunt, I hope it is possible to write about this domain without casting it as a system parallel to biomedicine or limiting our engagement to either its healing or harming potentials.

3. For a related analysis of similar trends in the history of medicine in sub-Saharan Africa, see Schumaker (2011).

4. The relationship between medical anthropology and the anthropology of religion is an important question that I plan to discuss in future writings, but a full discussion of the relationship between these two areas of inquiry is beyond the scope of this article.

5. For a related critique of the homogeneity of much of the current medical anthropology of sub-Saharan Africa, see Mkhwanazi (2016).

6. For an analogous career trajectory in the anthropology of Nepal, see Pigg (1996, 2001).

7. Many thanks to historian Marissa Mika for reminding me of this sobering fact.

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