

Prenotandum; this review of Olov Dahlin 2002, *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberenge District, Zimbabwe* (Frankfurt a.M., etc: Peter Lang)', was published in *AASR Bulletin* 22 (November 2004): 33-37

Jan G. Platvoet

AASR Bulletin Co-Editor

The Plurality of Healing

Olov Dahlin 2002, *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe*. Frankfurt am Main, etc.: Peter Lang, 295 pp., 6 appendices (glossary of Shona terms; list of abbreviations; list of interviews; list of institutions and events visited; summaries of the case histories; tables of questionnaire results), bibliography, frontispiece + 48 pictures, index of subjects, indexes of persons and places, 2 maps, 7 figures, ISBN 3-631-39576-0

The book

This PhD by a Swedish anthropologist and historian of religions was supervised by David Westerlund and defended at Uppsala University in 2001. It is based on two periods of research in medical and religious anthropology in the Mberengwa district in Zimbabwe: a preparatory one from October 1991 to February 1992, and a foundational one from March 1997 to March 1998. Its focus is the case histories of twenty patients who practiced religious and medical plurality by seeking help for their illnesses in different quarters: Western mission and government hospitals, Shona (Karanga) traditional healers, and AICs (African-initiated churches) practicing faith-healing and exorcism. The book consists of a preface, eight chapters, and an epilogue. In addition, it contains six substantial appendices (217-263), a bibliography (265-271), some fifty photographs (9, 273-292), and seven figures presenting data on the case histories and models.

The preface is quite lengthy (11-20). Dahlin describes in it what assistance he received from others and how the research affected him personally. His research was much furthered by the fact that his parents worked as medical doctors at the Mnene Lutheran hospital, the largest mission hospital in the Mberengwa district.

Not only did his parents assist him in the selection of the patients who could serve as research objects, but as the son of missionaries Dahlin also met with much goodwill from the many Lutherans in Mberengwa district, in which they constituted the largest mainline church. Dahlin furthermore lists his several ‘guides in the field’, and narrates how he met them, and how he spent his year of his research at Chief Mataga’s residence away from the comfort of mission hospitals, in order to experience the world of the rural Karanga ‘from within’ (12). He had a round hut built for him there and gradually learned to live life in the traditional way, even to the degree of realising towards the end of his stay that he had ‘actually acquired the insider view’ (15) and was having ‘traditionalist experiences’ (15-17). But the hardships and accidents of that life also made him fall ill, and share the experiences of the patients who were his objects of study (17-19). But he ‘never saw any spirits’ (23), as did Edith Turner, nor had religious experiences of the kind Young and Goulet gathered in *Being Changed: The Anthropology of Extraordinary Experience* (Ontario: Broadview Press, 1994).

Chapter 1, Introduction (21-47), is the methodological chapter, in which Dahlin details the aims of his research project, the questions at issue, his methodology of ‘reflexivity’, and his definitions of the central concepts of ‘ill health’, such as ‘illness’, ‘disease’ and ‘sickness’, and of ‘healing’, and ‘cure’. In addition, he surveys earlier relevant literature in medical African anthropology and in Shona, especially Karanga, ethnography and history, e.g. by students and staff of the Dept. of Religious Studies of the University of Zimbabwe at Harare, and by other Zimbabwean, Swedish and other European researchers. He also delineates his ‘field material’ and the three methods he used to obtain his data: participant observation, oral interviews and questionnaires. He used the first two in his research on action taken to remedy ill health in the extended family of Chief Mataga, who was a Lutheran by upbringing, a ‘traditionalist’ by practice, and a Zionist when he saw cause. His four surviving wives, sons, daughters and grandchildren represented all the religious traditions of the area: the mainline churches, Karanga indigenous religion, and the Pentecostal and Neo-Pentecostal AICs. Four members of Mataga’s family were spirit mediums (*masviriko*); three of them, and another member, were ‘healers’ (*n’anga*); two were AIC ‘faith healers’; and one was a Western-trained medical doctor (37). Lastly, Dahlin briefly describes the two ‘sources of his theoretical inspiration’ (43): social anthropology and the comparative study of religions. From them he derived his understanding that ‘the social context is indispensable for a

proper representation of religion in any society', but also his conviction that religion 'cannot be explained only by its social function and role in society' (43). Dahlin's approach is, therefore, contextual and non-reductionist. Furthermore, he departs from the assumption that 'reality is thoroughly pluralistic in nature', for it consists of the 'many worlds in the world' which humans construct by postulating certain things about reality and holding certain worldviews in order to make life meaningful (43-44). Illness puts that perceived order to the test and may involve a re-ordering of the world of a patient by means of an aetiology, or 'explanation', in order to find new meanings and regain control. Dahlin's thesis focuses on the pragmatics of the quest for therapy in a world of religious and medical pluralism.

The subject of Chapter 2 (49-69) is the ethnography of the Mberengwa district. It is ethnically pluralistic, but has a majority of Karanga-Shona. 'Ethnicities', however, are fading through intermarriage. Dahlin reviews the colonial and postcolonial history of the district, its traditional and modern politics, its economy, housing and nutrition, and Karanga kinship, gender divisions, and sociability, and how these have been affected by the benefits and ills of (Western) 'modernity' introduced by missions, education, medical care, mining industry and job mobility. Among the ills Dahlin reckons alcoholism, moral dissolution, increased crime rates, and the spread of HIV/AIDS. In religious matters, modernity has resulted in religious eclecticism: 'commonly people combine traditional beliefs with some aspects of Christianity' (69).

The religious plurality of the Mberengwa district is delineated in greater detail in chapter 3 (71-97) by surveys of Karanga indigenous religion (71-82), the 'mission churches' (82-87) and the AICs (87-92). In its last section (92-97), Dahlin examines how these three religious traditions have interacted. He also notes 'indications of secularisation among those who are socially and economically marginalised' (97).

The medical plurality of the Mberengwa district is examined in chapter 4, first, by a survey of indigenous medicine and healing, which is the domain of the *n'anga* (healers, herbalists), but may also involve the *masviriko* as 'mediums' of the *vadzimu* ('ancestors'), who are believed either to battle the *varoyi* ('witches') as the cause of illness, or to permit them to inflict disease (99-106). He then describes the history of modern curative health care in the district (106-111) and how the latter is ideally complemented in mission hospitals by 'Christian care' (111-112). 'Christian healing', however, is practiced only by the AICs. Their Spirit-inspired

prophets and healers blame illness on the *mudzimu* ('ancestors') or *mashave* ('foreign spirits') of indigenous religion and exorcise them as 'evil spirits' (112-117). The few Neo-Pentecostal churches in Mberengwa, however, do not 'heal', but make glossolalia their central feature. Dahlin concludes the chapter with a comparison of the three medical systems through a discussion how they complement each other in some respects, are each other's rivals in others, and have failed to 'integrate' into the one national health system planned by the government of Zimbabwe, because of their fundamentally different worldviews, their incompatible aetiologies of ill health, and their depreciative and separatist attitudes towards each other (117-124).

In chapter 5 (125-142), six case histories are extensively discussed, four of which occurred in Chief Mataga's family. In chapter 6 (143-181), they and the fourteen other case histories, described in appendix 5 (231-247), as well as the data obtained through the questionnaires (160-171, appendix 6: 249-263), are compared in respect of the social situation of the patients, their religious affiliations, their views of their illnesses, the aetiologies they held, the kinds of help they sought, and why they sought those particular types of help, and how they viewed the three medical systems. These two chapters amply document the prevailing medical inclusivism: even believers, who were staunch adherents of one particular religious option as long as they enjoyed good health, resorted to consulting the 'healers' of another religious alternative, or both other religious alternatives, when they were confronted with a severe illness and failed to obtain a cure from their 'own healers'. This medical eclecticism was fostered by the religious plurality prevailing in extended families and the neighbourhood. Whereas nuclear families might be mono-religious, extended families and neighbourhoods were pluri-religious and often counted indigenous and faith healers among their members (145-147, 158). Though 'patients usually try hospital care as the first alternative' (178, 180), distance, poor bus services and the costs of hospital treatment and Western medicines often caused families to opt first for the indigenous and/or faith 'healers' nearby and seek hospital treatment only after the local healers had failed to restore health (147-150). Hospitals were also not consulted when the ill health was perceived as caused by witches, ancestors, or 'evil spirits', and in need of ritual instead of biomedical treatment (151-155, 179), or in need of both (180). Dahlin concludes this chapter by comparing his findings with those of other scholars of Shona societies and other African societies and by drawing a few general

conclusions (171-181). One respects the tendency to diminish attribution of illness to God, ancestors and nature spirits, and to increase attribution to natural (biomedical) causes and to 'witches'. This change reflects the increasing Christianisation, secularisation and individualisation of African societies and the growth of competition and tension in them (176-178). Dahlin agrees with Westerlund that indigenous African therapy systems have always been plural: its aetiologies comprised both natural and 'cultural'¹ (culturally attributed) causation. It could, therefore, easily integrate the Western biomedical care as a complement to its own multidimensional and flexible system (181).

Chapter 7 (182-205) concludes Dahlin's thesis by means of an *emic*, or 'inside', analysis of the 'life-worlds' of the patients, whose multi-episodic ill-health histories have been described in the book. The 'life-world of a patient' refers to how a patient experiences his or her 'world', and in particular his or her ill health, and the meanings which she or he attributes to it (17, 44). Dahlin investigates the concepts of 'health' and 'well-being' of these Karanga patients (182-185), the natural and 'cultural' causes to which they attribute ill health (186-187), the different 'healing' processes for which they opt (187-191), and the noxious or curative effects which these causes and processes have on the (minds of the) patients by the ways in which they understand and experience them (192-196). By these mental effects, illnesses and healings are not merely physiological, but also psychosomatic and culturo-somatic processes (211). Not only physiological pathogens need to be neutralised in healings, but also the psychological and cultural 'pathogens' (of 'social or spiritual origin' [197]) need to be addressed at their own levels and in their own idioms. Dahlin says: 'From this perspective both these medical systems [the indigenous and faith healing ones, which acknowledge the prevailing beliefs in witches, JP] – seem rational' (198). He suggests that there is a two-way interplay between body and mind, and that neuro-peptides serve as a means of communication between them. Actually, we should do away with the body-mind dichotomy, for there is only, Dahlin says, an 'embodied mind' and a 'minded body'. Which is why illness involves both the body and the mind, and also his or her cultural and natural outer worlds in as far as they are significant for the life-world of a patient. Biomedicine needs to review its Cartesian positivist legacy of the separate body and mind and its exclusive concern with physiological

¹ Dahlin avoids 'spiritual causation', because the term 'spiritual' suggests a separation between the 'spiritual' and the 'natural' worlds, which Karanga believers clearly do not hold, for they regard and experience them as integrated in their world (44n71).

pathogens and lesions. It needs to appreciate the multi-dimensionality of illness, and it may learn much from ritual healing in respect of psychosomatic and culturo-somatic illnesses (200-205).

Appreciation

The summary of the book's contents presented above demonstrate that Dahlin's thesis is a model, methodologically and content-wise, of a research project into the important interface between the medical and religious domains, in particular in Africa where religious and medical plurality is a notable feature virtually everywhere. For that reason, one would wish that at least one copy of this thesis were present in all university libraries in Africa for inspection by staff and students of Departments for the Study of Religions and of the Social Sciences in order that they might study the book not only for its contents, but in particular for Dahlin's research methods, and the manner in which he has presented the outcome of research in this book.

I have but one critical note. It respects Dahlin's thesis that illness is caused not only by physiological pathogens (the disease causing agents which Western biomedicine is eager to trace and cure), but also by cultural 'pathogens of social and spiritual origin' (197). I agree that these should be ritually addressed by the appropriate healer in order to bring relief, and perhaps healing, to the patient whose health has been adversely affected by e.g. belief in witches and their perceived 'evil craft'. Dahlin should, however, perhaps have taken another step also. As biomedicine not only combats biological pathogens – bacteria and viruses –, but also tries to eradicate them and the diseases they cause, certain cultural pathogens, such as the belief in witches and their alleged witchcraft, need not only be ritually combatted by religious healers for relief, but also need to be eradicated for the social harm they cause, as the history of European and African witch-beliefs amply demonstrates. But that cannot be done by healers, for they have a vested interest in these beliefs. It takes teachers to do that. Dahlin's thesis certainly makes a contribution to that (unintended) greater aim.